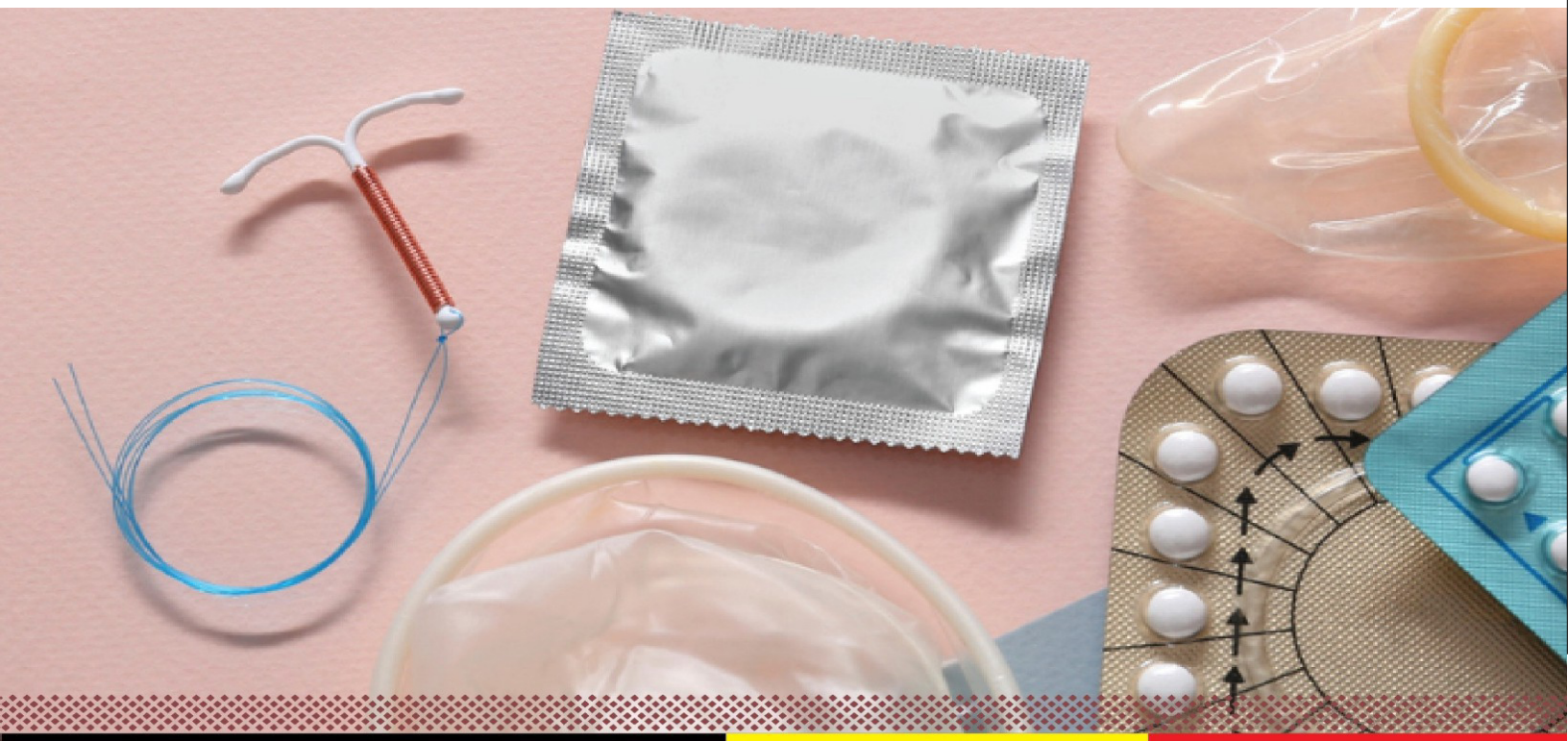
TRENDS IN FAMILY PLANNING AND RELATED INDICATORS

BASED ON UDHS 2022



OCTOBER 2025

THE REPUBLIC OF UGANDA

Trends in family planning and related indicators

Based on the Uganda Demographic and Health Survey (UDHS) 2022

OCTOBER 2025

This report presents trends of Family Planning indicators in Uganda based on a further analysis of the Uganda Demographic and Health Survey 2006-2022, undertaken by the Uganda Bureau of Statistics.

Additional information about the Survey may be obtained from Uganda Bureau of Statistics, Statistics House, Plot 9 Colville Street, P.O. Box 7186, Kampala; Telephone: (256-414) 706000; Email: ubos@ubos.org; Website: www.ubos.org.

Recommended citation: Uganda Bureau of Statistics (UBOS), 2025. Trends in Family Planning and related indicators Based on UDHS Data, 2006 – 2022. Kampala, Uganda; UBOS.

PREFACE

Iam pleased to present to you this summary Report on Trends in Family Planning and Related Indicators generated from the Uganda Demographic and Health Survey (UDHS) series from 2006 - 2022. This Report was developed in response to the increasing demand for specific statistics on Family Planning, that are always embedded in a stand - alone survey, the UDHS conducted every 5 years. This summary Report, therefore, highlights the trends and patterns on Family Planning, the level of accessibility, sexual patterns among different age groups and the resultant effect on fertility.

Currently Uganda is undergoing a demographic transition characterized by high population growth, a youthful age structure, with over half of Uganda's population under the age of 18, making it one of the youngest in the world. While this presents both challenges and opportunities, Uganda is uniquely positioned to harness a "demographic dividend" if strategic investments are made in education, healthcare, and infrastructure. Adoption of policies and interventions aimed at accelerating a decline in fertility and mortality, thus presenting a healthy, skilled, innovative, business oriented and economically active population are pivotal to socio-economic transformation.

Statistics on Family Planning, therefore, are crucial in achieving the foregoing objectives. Government and her partners, including development partners, Civil Society Organizations (CSO), the Private Sector and the Media will find the data in this Report critical in enhancing further, advocacy for increased rollout of Family Planning initiatives.

The Bureau expresses deepest appreciation to the Government of Uganda and the United Nations Population Fund for the financial support towards the compilation of this thematic report. The technical contribution from the Ministry of Health, Makerere University-School of Public Health and experts in the field of reproductive health is also appreciated.

The Bureau appeals to all decision makers, policy makers, researchers, the Academia and the public to utilize this report for evidence-based planning and decision making to design interventions that will enhance social well-being of the population.

Chris **N.** Mukiza (PhD)

EXECUTIVE DIRECTOR

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1. Introduction

Uganda has experienced significant demographic changes over the past few decades, in both fertility and mortality. The country's population has been growing rapidly, with a youthful population that continues to shape its social, economic, and political landscape. Fertility rates in Uganda have historically been high, contributing to the nation's expanding population. However, trends have been evolving as the government, alongside various stakeholders, has worked to address the challenges posed by rapid population growth. Family planning has become a critical focus area as a cornerstone of public health and development in Uganda, playing a crucial role in improving maternal and child health; reducing fertility rates; and promoting economic stability.

The Uganda Demographic and Health Surveys (UDHSs) have been a key source of data for understanding trends in family planning practices, providing valuable insights into the country's reproductive health landscape. Over the years, these surveys have tracked various family planning practices, and reproductive health outcomes, shedding light on the availability, accessibility, utilization, and effectiveness of family planning services across different demographic groups.

This report focuses on the trend analysis of family planning indicators derived from the UDHSs, exploring how these indicators have evolved over time. By examining awareness of family planning methods, fertility preferences, and patterns in contraceptive use, the report aims to highlight key developments, challenges, and opportunities in Uganda's family planning landscape. Through this analysis, the report seeks to provide a comprehensive understanding of the progress following implementation of robust family planning programs, contributing to the broader goal of improving reproductive health and development outcomes in Uganda.

2. Population Growth

Uganda has a population of 45.9 million people, 49.6 percent are children below 15 years, who are dependents. Between 2014 and 2024, the population grew at a rate of 2.9 percent annually. The dependency ratio, an indicator of the economic burden that the productive population must bear, is an age-population ratio of those not in the working Age group (the dependent persons aged 0 to 14 and 65+) to those in the working Age group (15-64) has been declining. The overall age dependency ratio was 83.8 in 2024 having reduced from 103.2 in 2014, meaning that for every 100 working age persons there were 84 age-dependent persons (Table 1). Of the 84 dependents, 78 were children.

Table 1: Dependency ratios 1991 – 2024

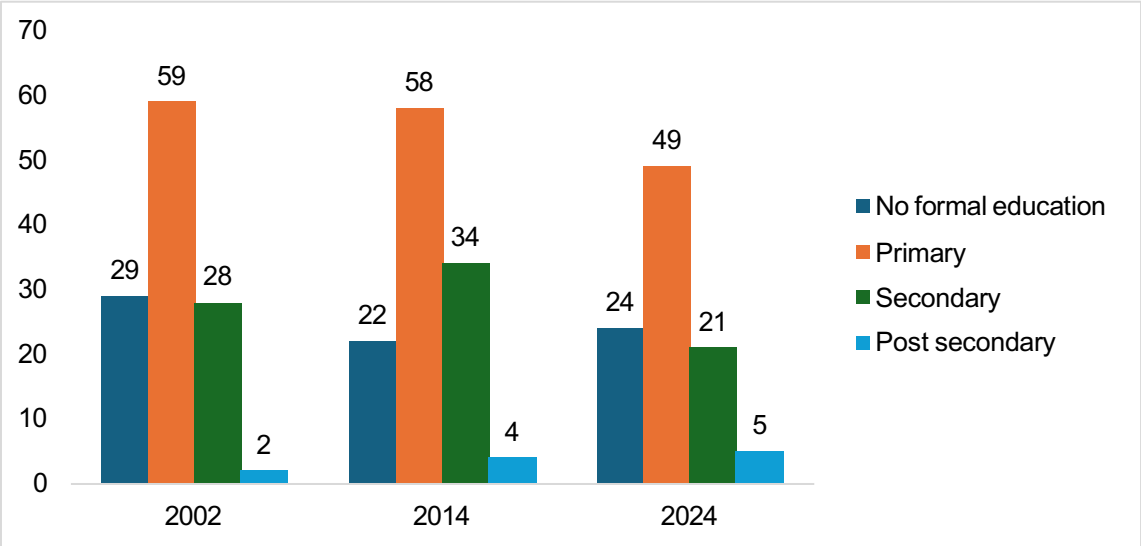
Year	Total Population	Working age group 14-64	Population <15years	Population 65 and above	Dependence Ratio
2024	45,905,417	25,155,922	19,397,602	1,532,750	**83.8**
2014	34,634,650	17,040,977	16,603,149	993,357	**103.2**
2002	24,227,297	11,650,184	12,054,626	706,090	**110.2**
1991	16,671,705	8,227,418	7,880,481	556,264	**103**

Source: National Population and Housing Census reports.

3. Education Attainment

Education, especially of women, is closely associated with other socioeconomic factors such as income and economic activity, as well as with reproductive decisions and behavior, including on when to have children, family size and use of contraception. These depend on the level of educational attainment. Women who have completed secondary school make more meaningful decisions compared to those without formal education or those who completed primary school. Figure 1 shows the country registered better progress between 2002 and 2014. There were fewer women who didn't have formal education (29%) and those who completed primary (59%) in 2002. Yet these were 22 percent and 58 percent respectively in 2014. On the other hand, 34 percent of women completed secondary school compared to only 28 percent in 2002.The trend is reversed back in 2024, possibly because of the high dropout rates that were registered during the COVID-19 pandemic in 2020 and 2021. The number of children who completed secondary school dropped by 13 points between 2014 and 2024.

Figure 1: Educational attainment among Women aged 10 and above, 2002 – 2024



Source: National Population and Housing Census reports.

4. Marriage

4.1 Marital Status

Marriage is a demographic event that influences exposure to pregnancy and thereby affects fertility. The trend from 2006 to 2022 shows an increasing percentage of women aged 15-19 who have never been married (77.6% in 2006 compared to 79.7% in 2022) and a decreasing percentage in women aged 15-19 currently in union from 19.6 percent in 2006 to 17 percent in 2022. Most women are married by age 20-24; less than 20 percent remain single after age 30. Over time, age at marriage has been constant but has increased slightly from 77 percent in 2016 to about 80 percent in 2022 (Table 2).

Table 2: Trend in percentage of women by age group and marital status

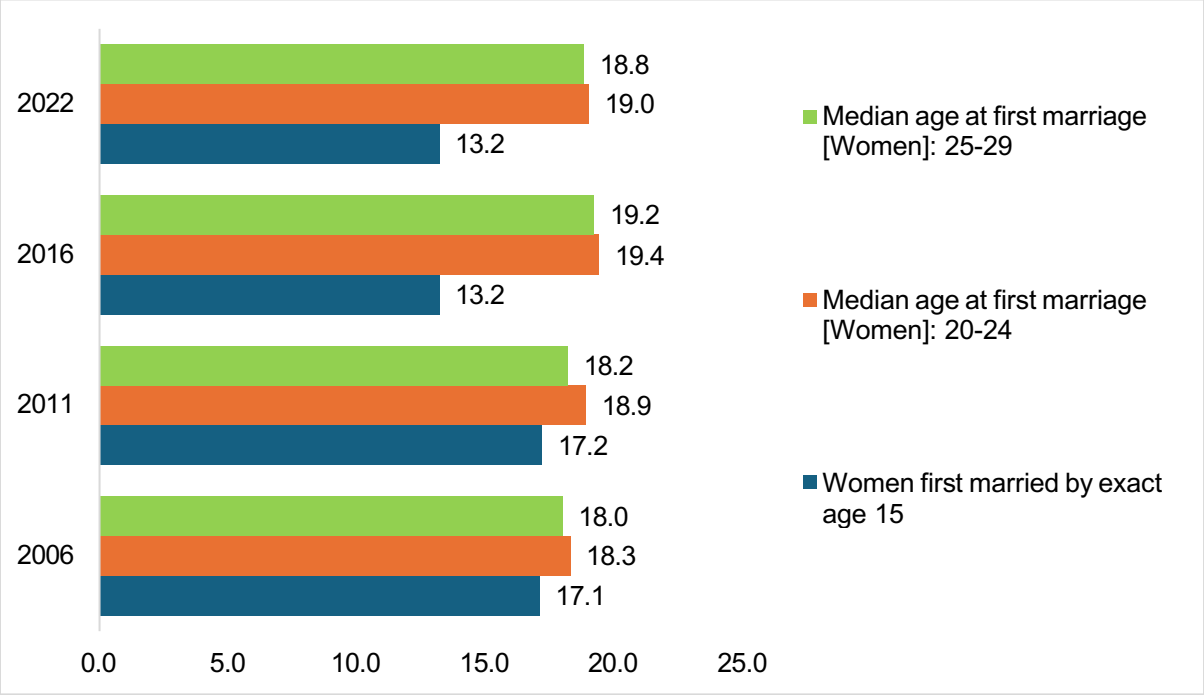
Age group	2006		2011		2016		2022	
	Never married	Currently in union	Never married	Currently in union	Never married	Currently in union	Never married	Currently in union
15-19	77.6	19.6	77.3	20.0	77.2	19.9	79.7	17.0
20-24	21.9	67.1	23.9	67.3	25.5	64.0	25.0	63.1
25-29	5.8	80.4	5.6	82.5	10.0	77.3	8.8	75.7
30-34	2.8	81.6	2.3	81.1	3.9	78.5	3.7	80.3
35-39	1.9	78.1	1.5	79.9	2.7	77.1	2.2	79.5
40-44	1.8	73.3	0.8	75.8	2.4	73.6	2.3	74.2
45-49	0.7	70.3	2.2	62.0	1.5	69.6	2.9	65.8
15-49	**23.8**	**62.6**	**24.4**	**62.5**	**25.8**	**60.6**	**24.7**	**60.8**

Source: Uganda Demographic and Health Survey

4.2 Median age at first marriage

The median age at first marriage refers to the age at which half of people have married. A later median age at first marriage is generally associated with lower fertility rates, as it reduces the period of a woman's reproductive life during which she is exposed to the risk of pregnancy. Later marriages often correlate with women having more time for education and employment, which can lead to greater autonomy and access to family planning resources, further contributing to lower fertility rates. Figure 2 shows that the median age at first marriage has generally been increasing in recent decades among women aged 20-24. While the share of women married (first marriage) at exact age 15 decreased from 17.1 percent in 2006 to 13.2 percent in 2016 and remained stagnant in 2022.

Figure 2: Median age at first marriage



Source: Uganda Demographic and Health Survey

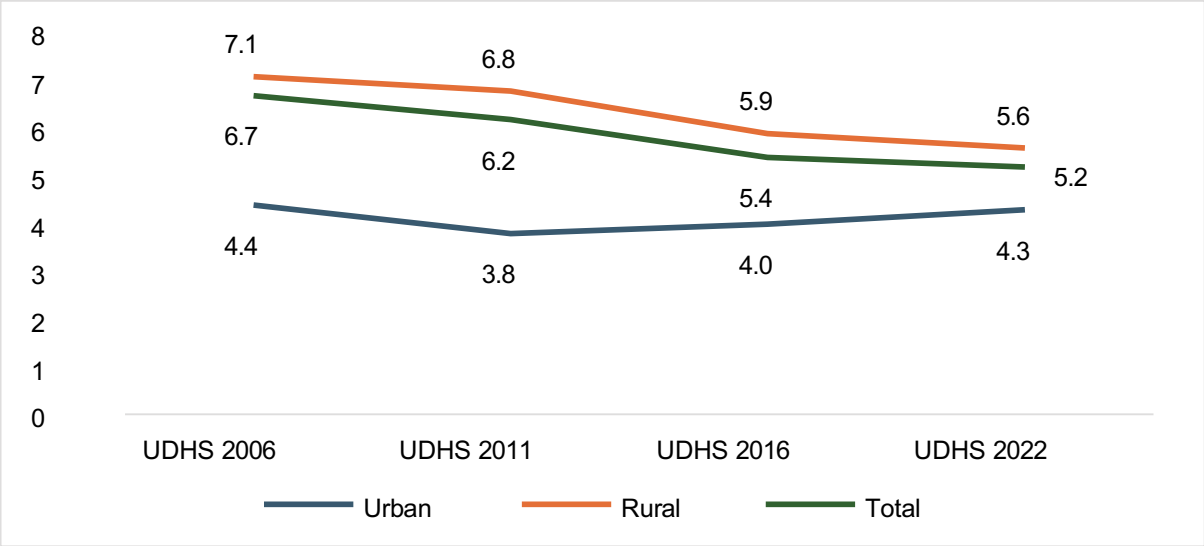
5. Fertility

Uganda has long been characterized by its high fertility rate but significantly declined by 35 percent from 7 children per woman in 2002 to 4.5 in 2024 (Figure 3). This shift can be attributed to several interrelated factors, including increased access to family planning services, changing societal norms, greater awareness of reproductive health, and government policies aimed at promoting smaller family sizes. As of the most recent demographic data, Uganda remains one of the youngest and fastest-growing populations in the world. This demographic profile has significant implications for the country's economic development, social services, and overall public health. The country's high fertility rate, defined as the average number of children a woman is expected to have during her lifetime, is attributed to the deep-rooted cultural, socio-economic, and health-related factors.

The Government of Uganda, along with partners, has made concerted efforts to improve access to contraception and reproductive health education. The expansion of family planning programs, including the distribution of contraceptives and the implementation of community-based health outreach initiatives, has contributed to a steady increase in contraceptive use among Ugandan women. Despite these advances, challenges remain, such as limited access to services in rural areas, cultural resistance to family planning, and gaps in education and awareness about contraceptive methods.

The UDHS data reveals significant disparities in fertility rates based on factors such as geographic location, education levels, wealth, and urban versus rural residence. For example, women in urban areas and those with higher levels of education tend to have fewer children compared to their rural counterparts. Additionally, the availability of family planning services remains inconsistent, with some regions experiencing more robust access to contraceptives and maternal health care than others.

Figure 3: Trends in Total Fertility Rate for Uganda



Fertility among women using contraception

Contraception allows women to control their fertility, enabling them to choose when and if to have children, which can lead to improved maternal health and reduced unintended pregnancies. Table 3 shows that women using any contraceptive method had a higher TFR (6.0 children per woman) compared to those not using any method (4.8 children per woman).

Table 3: Total Fertility Rate by Age group and contraceptive use status among women aged 15-49

Age group	Not using any method	Using any method	Not Using modern method	Using modern method
15-19	0.094	0.234	0.096	0.242
20-24	0.218	0.295	0.220	0.300
25-29	0.230	0.259	0.233	0.257
30-34	0.203	0.206	0.205	0.203
35-39	0.148	0.138	0.152	0.130
40-44	0.062	0.065	0.065	0.059
45-49	0.008	0.009	0.008	0.010
TFR	**4.8**	**6.0**	**4.9**	**6.0**

Source: Uganda Demographic and Health Survey 2022

6. Sexual Activity

6.1 Median age at first sexual intercourse for women (20-49 and 25-49)

Age is a key determinant of sexual debut. With increasing age, there is a larger proportion of young people reporting sexual activity and the median age at first intercourse is usually in the mid to late teens. Early sexual initiation, as indicated by a younger median age at first sex, is associated with an increased risk of unintended pregnancies, early motherhood, high fertility, and potentially poorer reproductive health outcomes, including increased risk of sexually transmitted infections.

Table 4 shows overall, for women aged 20-49 years, the median age at first sexual intercourse ranged between 16.1 – 17.1 years over the 21-year period (UDHS of 1995 – 2016). This has however declined to 16.8 years in a space of 6 years (UDHS, 2022). While for those aged 25-29 years, the median age at first sexual intercourse ranged between 16 –16.9 years over the 21-year period (UDHS of 1995 – 2016).

There are differences in the reproductive lives of rural and urban women, as well as in the level of education attainment. The median age at first sexual intercourse of rural women aged 20-49 years, is 16.7 ranging between 16.5 – 16.8 years over the 10 -year period (UDHS of 2006 – 2016). While for urban women it ranged between 17.2 – 17.8 years over the same period. Similarly, the median age at first sexual intercourse for rural women aged 25-49 years is 16.5 years in 2022. It ranged between 16.3 – 16.7 years over the 10-year period (UDHS of 2006 – 2016) while for urban women, it ranged between 16.8 – 17.6 years over the same period.

In summary, the median age at first sexual intercourse among rural women (25-49 years) is 0.4 years earlier than among urban women while the median age at first sexual intercourse among rural women (20-49 years) is 0.3 years earlier than among urban women. This means rural women start having sex much earlier (almost one-year early) than their counterparts in the urban setting across all ages. Overall, women in rural areas tend to experience first intercourse at a younger median age (20–49 years & 25-49 years) compared to women in urban areas over the 27-year period (UDHS 1995–2022).

The median age of women aged 20- 49 years with no education at first sexual intercourse, ranged between 16 – 16.4 years over the 15-year period (UDHS of 2006 – 2022) with an average age of 16.4 years. The median age at first sexual intercourse for women with primary education level, ranged between 16 –16.6 years. The median age at first sexual intercourse for women with secondary education, ranged between 17.7 – 18 years over the 21-year period (UDHS of 1995 – 2016).

For women aged 25-49 years with no education, their median age at first sexual intercourse ranged between 15.7 – 16.4 years over the 27-year period (UDHS of 1995 – 2022). The median age at first sexual intercourse for women with primary education level, their median age at first sex ranged between 15.9 – 16.5 years. Women with secondary education level, their median age at first sex ranged between 17.5 – 17.8 while those with higher level of education, their median age at first sex ranged between 19.3 – 23.1 years over the 27-year period (UDHS of 1995 – 2022).

There is a small observable difference of 0.3 years for the median age at first sexual intercourse ranged among women aged 20-49 years and those 25-49 years with no education over the 27year period (UDHS of 1995 – 2022). While for those with primary education level, the observed difference is just 0.1 years for the median age at first sexual intercourse. This means that the median age at first sexual intercourse for women with education was higher compared to that among women with no education regardless of the age.

Therefore, women's education plays a crucial role in delaying early sexual debut. Empowering girls with knowledge not only enhances their academic and career opportunities but also equips them with the information and confidence to make informed decisions about their bodies and relationships. Promoting education for women is a key strategy in preventing early sexual debut and its associated risks.

The evidence suggests that across both age groups (20-49 & 25-49) the median age at first sexual experience increases as women's wealth status rises. Studies across different time periods of UDHS (1995 – 2022) have shown that wealthier women tend to delay their first sexual experience by 0.7 – 1.6 years (among 20-49 years) and 0.6 – 2.4 years (among 25-49 years) compared to women from lower socio-economic backgrounds.

This delay can be attributed to the following factors:

1. **Education**: Wealthier women often have better access to education, which can lead to greater awareness of sexual health and a longer focus on career or academic goals before engaging in sexual activity.
2. **Access to healthcare**: Higher wealth status is correlated with better access to healthcare, including sexual and reproductive health services, which can influence decisions about when to initiate sexual activity.
3. **Cultural and social norms**: In wealthier communities, social norms may emphasize delayed sexual initiation as part of a broader focus on personal development, career-building, or family planning.
4. **Economic independence**: Wealthier women may experience more economic independence, allowing them to make decisions regarding sexuality based on personal preference rather than economic necessity or social pressures.
5. **Family dynamics**: Wealthier families may have more resources to invest in the upbringing of children, including instilling values and providing the necessary support for making informed decisions about relationships and sexuality.

Overall, the relationship between wealth status and the median age at first sexual experience highlights the intersection of socio-economic factors with personal and cultural decision-making processes.

Table 4: Median age at first sexual intercourse for women (20-49 and 25-49)

Characteristic	Survey Period	1995		2000-01		2006		2011		2016		2022	
	Age (Years)	**20-49**	**25-49**	**20-49**	**25-49**	**20-49**	**25-49**	**20-49**	**25-49**	**20-49**	**25-49**	**20-49**	**25-49**
	Total	16.1	16	16.7	16.6	16.6	16.4	17.0	16.8	17.1	16.9	16.8	16.6
Residence	Urban	16.4	16.3	17	16.9	17.2	16.8	17.6	17.4	17.8	17.6	17.0	16.9
	Rural	16.1	15.9	16.6	16.6	16.5	16.3	16.8	16.7	16.8	16.7	16.7	16.5
Education level	No education	15.8	15.7	16.4	16.4	16.2	16.1	16.4	16.3	16	16	16.4	16.3
	Primary	16	15.9	16.4	16.4	16.3	16.2	16.6	16.5	16.6	16.5	16.3	16.2
	Secondary	17.8	17.6	17.9	17.8	17.7	17.5	17.8	17.7	18	17.8	17.7	17.4
	Higher	NA	23.1	19.2	19.3	19.4	19.7	NA	20.3	19.8	19.8	19.6	19.6
Wealth Index	Lowest	15.9	15.9	16.3	16.2	16.3	16.3	16.6	16.6	16.5	16.4	16.6	16.5
	Second	16	15.9	16.6	16.6	16.4	16.3	16.9	16.8	16.6	16.4	16.5	16.4
	Middle	15.9	15.7	16.6	16.7	16.6	16.4	16.9	16.6	16.8	16.6	16.6	16.4
	Fourth	16.3	16.1	16.5	16.4	16.3	16.1	16.7	16.5	17.2	17	16.8	16.6
	Highest	16.6	16.5	17.2	17.2	17.1	16.9	17.6	17.4	18.1	17.9	17.5	17.3

Source: Uganda Demographic and Health Survey

6.2 Median age at first sexual intercourse for men (20-49 and 25-49)

Table 5 shows the median age at first sexual intercourse for men aged 20-49 years ranged between 17.5 –18.8 years over the 27-year period (UDHS of 1995 – 2022) as shown in Table 5. While the median age at first sexual intercourse for those aged 25-49 years, ranged between 17.6 –18.8 years over the 27-year period (UDHS of 1995 – 2022. Between 20-49 and 25-29 years, there is no much observable difference in the median age at first intercourse among men with 0.1 years difference across the 27 years of the UDHS (1995 – 2022)

When we look at residence, the median age at first sexual intercourse for rural men aged 20-49 years, ranged between 17.6 – 18.9 years while for urban women it ranged between 16.9 – 18.5 years over the 27-year period (UDHS of 1995 – 2022). Similarly, the median age at first sexual intercourse for rural men aged 25-49 years, ranged between 17.6 – 18.9 years and for urban men, it ranged between 17.2 – 18.6 years over the 27-year period (UDHS of 1995 – 2022).

In summary, the median age at first sexual intercourse among rural men (25-49 years) is 0.1 years earlier than among urban men while the median age at first sexual intercourse among rural men (20-49 years) is 0.3 years earlier than among urban men. This means, across both ages, rural and urban men start their first sexual intercourse almost at the same time.

In terms of education, across all ages, men with higher education have their median age at first sexual intercourse slightly later than those with no education and a bit more later than those with primary and secondary education. The relationship between educational attainment and the median age at first sexual intercourse can be explained by several socio-economic, psychological, and cultural factors to include;

Social and Economic Stability:

This shift can be attributed to several interrelated factors, including increased access to family planning services, changing societal norms, greater awareness of reproductive health, and government policies aimed at promoting smaller family sizes. Individuals with higher education are often more likely to be financially stable and secure in their careers, which may lead them to delay certain life events, including sexual activity. This delay might be linked to prioritizing academic and career goals before engaging in intimate relationships.

- On the other hand, individuals with no education face challenges related to economic insecurity, which can sometimes influence earlier sexual activity, potentially as a result of seeking emotional connection or other socio-cultural factors.

Cultural and Family Norms:

- Educational attainment can influence cultural norms and values. In many societies, higher education is associated with delayed marriage and starting families, which often correlates with delayed sexual activity. More educated people are more likely to have access to comprehensive sexuality education, which may lead to making better informed decisions about the timing of sexual activity. Those with primary or secondary education might be influenced by peer pressures, socio-economic conditions, or cultural expectations.

Access to Information:

- Higher education often provides individuals with more access to knowledge about sexual health, contraception, and the consequences of early sexual activity. With better information, individuals might make more informed decisions about delaying sexual initiation until they feel ready.
- Those with lower levels of education, or none at all, might have limited access to comprehensive sexual education, which can lead to earlier initiation of sexual activity, possibly due to lack of awareness or lower perceived risks.

The median age at first sexual intercourse is not different for all ages, across all wealth statuses for men. Therefore, the median age at first sexual intercourse for men may not be strongly influenced by wealth status for a variety of reasons, which can be understood within the context of socio-economic, cultural, and policy factors such as;

Cultural and Social Norms:

In many communities in Uganda, there are strong cultural expectations surrounding masculinity, sexual initiation, and rites of passage. In some areas, young men may feel social pressure to engage in sexual activity at an early age, regardless of their wealth or economic status. These norms often emphasize early initiation of sexual activity as part of proving one's maturity or manhood, particularly in more rural or traditional settings. Wealth status might not be as influential when it comes to the timing of sexual initiation because the societal emphasis on proving masculinity through early sexual activity can override economic factors.

Access to Sexuality Education:

While wealthier individuals in many countries often have better access to education, including sexuality education, this may not be as pronounced in Uganda. In rural areas where both wealthy and poor individuals might receive limited sexuality education there may be limited access to sexuality education programs. As a result, the age at first sexual intercourse may be less about wealth and more about limited information or social norms. Comprehensive sexuality education may be insufficient, particularly in lower-income areas, meaning that a lack of awareness about contraception, the risks of early sexual activity, and reproductive health could contribute to early sexual debut regardless of wealth.

Economic and Gender Expectations:

While wealth status can affect access to resources like education and healthcare, many Ugandans, particularly in rural areas, might experience less economic disparity in terms of sexual activity. In rural areas, where a large portion of the population resides, factors like agriculture-based livelihoods, early marriage, or cultural traditions might take precedence over wealth in shaping when young men first engage in sexual activity. Uganda being a patriarchy society, there are gendered power dynamics, roles and expectations influencing reproductive choices, and ultimately, fertility. For young men, sexual initiation might be more related to peer pressure, community expectations, and family dynamics than to individual financial standing. There may be a belief among some young men that sexual activity or sexual relationships are a way to establish or assert their social status, particularly if they perceive sexual success as tied to their social identity or masculinity. This can lead to earlier sexual experiences, regardless of their economic background.

On the other hand, most patriarchal societies control the mobility of women and their reproductive decisions. Women, irrespective of their economic status have no right to decide when or whether they are ready to have sexual intercourse, whether they want to be mothers, when they want to be, the number of children they want to have, whether they can use contraception or terminate a pregnancy and so on and so forth. Even girls from wealthier families may not be immune to these cultural pressures, and therefore, wealth status may not play as significant a role in influencing the age at first sexual intercourse as other factors such as community norms, family expectations, or peer behaviour.

Role of Peer and Family Influence:

Peer pressure and family dynamics are significant drivers of early sexual activity, particularly in environments where there are limited opportunities for youth to pursue long-term educational or career goals. Wealth may not be as relevant if young men face significant pressure from their peers or families to engage in sexual activity at an earlier age. In some cases, wealthier families may still have traditional beliefs or community pressures that encourage early sexual initiation, while poorer families might be similarly influenced by these cultural norms.

Conclusion: The median age at first sexual intercourse for men in Uganda is likely influenced more by deep-rooted cultural, social, and gender norms than by wealth status alone. Socio-economic factors, while important, may not be as significant as other forces such as peer pressure, traditional expectations, and limited access to sexuality education or healthcare, which can impact sexual behaviour across different wealth strata.

Table 5: Median age at first sexual intercourse for men (20-49 and 25-49)

	UDHS Period	1995		2000-01		2006		2011		2016		2022	
	Age (Years)	**20-49**	**25-49**	**20-49**	**25-49**	**20-49**	**25-49**	**20-49**	**25-49**	**20-49**	**25-49**	**20-49**	**25-49**
	Total	17.5	17.6	18.8	18.8	18.1	18.1	18.5	18.6	18.4	18.5	18.2	18.3
Residence	Urban	16.9	17.2	18.5	18.6	18.1	18.4	18.4	18.6	18.4	18.6	18.2	18.4
	Rural	17.6	17.6	18.9	18.9	18.1	18.0	18.6	18.5	18.4	18.4	18.1	18.3
Education level	No education	18.1	18.3	19	18.9	18.2	18.2	17.9	18.0	18.4	18.4	18.7	18.9
	Primary	17.4	17.4	18.9	18.9	18.0	18.0	18.5	18.5	18.2	18.4	17.9	18.1
	Secondary	17.4	17.5	18.4	18.4	18.2	18.2	18.5	18.5	18.4	18.5	18.2	18.3
	Higher	17.6	17.9	19.9	20.1	18.5	18.6	19.7	19.9	18.9	18.8	18.8	18.9
Wealth Index	Lowest	17.3	17.2	18.6	18.6	18.2	18.3	18.4	18.4	18.2	18.3	18.2	18.3
	Second	17.7	17.8	19.1	18.9	17.9	17.8	18.4	18.4	18.2	18.2	18.1	18.3
	Middle	17.4	17.3	19	19	18.3	18.2	18.6	18.6	18.3	18.4	17.8	18.1
	Fourth	17.7	17.8	18.8	18.9	18.1	18	18.6	18.6	18.4	18.5	18.2	18.4
	Highest	17.3	17.7	18.8	18.9	17.9	18.1	18.6	18.7	18.7	18.8	18.4	18.5

Source: Uganda Demographic and Health Survey

6.3 Never had sexual intercourse (women)

Sexual abstinence among adolescents and young adults is a reproductive health-promoting behaviour to prevent negative sexual outcomes, such as sexually transmitted infections, and unintended pregnancies. There has been a growing number of adolescents and young people delaying sexual initiation. The percentage of women who never had sexual intercourse has been higher (more than half) among the 15–19-year-olds across all the UDHS periods (Table 6). This percentage, however, significantly reduces as age bands move upwards. Many young girls aged 15-19 years are still in school, and education is often a priority. Schools and educational systems in Uganda have programs that encourage young people, particularly girls, to abstain from sex and delay sexual initiation to focus on their studies. As girls enter their 20s, they may transition out of formal education and into adult responsibilities, which can lead to a greater likelihood of engaging in sexual activity.

Table 6: Percentage of Women who have Never had sexual intercourse

UDHS Period		1995	2000-01	2006	2011	2016	2022
Age group	15-19	54.3	52.7	54.9	52.7	54.3	55.6
	20-24	7.8	5.6	8.2	5.6	7.8	5.9
	25-29	1.4	0.7	0.8	0.7	1.4	1.1
	30-34	0.9	0.4	0.8	0.4	0.9	0.5
	35-39	0.3	0.1	0.2	0.1	0.3	0.2
	40-44	0.5	0	0	0	0.5	0.2
	45-49	0.1	0	0	0	0.1	0.3

Source: Uganda Demographic and Health Survey

Several factors, including a combination of social, cultural, and biological factors can explain the higher percentage of women aged 15-19 who have never had sexual intercourse, compared to those with older ages. While abstinence is promoted, there is also a growing recognition of the need for comprehensive sexuality education, and through programs, like the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY), which emphasize delaying sexual activity until marriage as a key strategy for HIV prevention.

Younger Age:

Adolescents, particularly those in the 15-19 age range, are still in the process of developing emotionally, physically, and socially. Many women in this age group may not feel ready for sexual activity or may still be focused on education and personal development. As women grow older, particularly in their early 20s, they may experience changes in their social, emotional, and physical maturity that can lead to increased interest in sexual relationships.

Cultural and Social Norms:

In many societies, there are strong cultural and social expectations about when sexual activity is appropriate. In Uganda, sexual activity is often viewed as something that should happen within the context of marriage or long-term relationships. Younger women (15-19) may delay sexual activity because of cultural values and religious beliefs and practices that emphasize chastity or waiting until they are older or in stable relationships.

Peer Influence and Group Behaviour:

During adolescence, peer influence can play a significant role in shaping sexual behaviour. Peer pressure and social expectations within a community can also contribute to early sexual debut. Persons aged 15-19 may have a higher percentage of peers who influence them to delay or initiate sexual activity. As they enter their 20s, they may face different peer dynamics, including increased pressure to engage in sexual relationships or to "catch up" with peers who are already sexually active.

Marriage and Partnership Trends:

In many societies, marriage tends to occur later in life, and many women in the 15-19 years age range are not married. As marriage is often linked with the onset of sexual activity, the delay in marriage leads to a higher percentage of young women who have never had sexual intercourse. In contrast, as women move into their 20s and beyond, they are more likely to engage in intimate relationships or marriages, which is often associated with sexual activity.

Access to Contraception and Reproductive Health Services:

Younger women, especially those under 20, may face barriers to accessing contraception or sexual health services, either due to lack of knowledge, social stigma, logistical challenges and attitudes of health workers. As women age and become more independent, they may gain better access to reproductive health resources, leading to increased safer sexual activity. However, some may still choose to delay sex or remain abstinent for personal, social, or cultural reasons.

Conclusion: The higher percentage of women aged 15-19 who have never had sexual intercourse compared to those aged 20-24 and older can be attributed to a combination of factors, including biological and emotional development, cultural and social norms, education, marriage patterns, and access to sexual health resources. As women age, they tend to experience greater social and emotional readiness for sexual relationships, often in the context of marriage or long-term partnerships, which leads to a higher likelihood of sexual activity in the 20 - 24 age group and above compared to the 15-19 group.

6.4 Never had sexual intercourse (men)

The trend seen among the 15–19-year-old women is not any different from that of the men of the same age group. However, this trend somehow differs when it comes to 20–24-year age group for men (Table 7). In Uganda, the higher percentage of men aged 20-24 who have never had sexual intercourse compared to women in the same age group can be explained by several factors:

1. **Cultural Expectations and Gender Norms**: Cultural norms often place pressure on women to engage in sexual activity as part of their roles in family and marriage, while men, particularly in their 20s, may face societal expectations that focus on economic stability and career development before engaging in sexual or romantic relationships.

2. **Marriage and Partnership Patterns**: Women in Uganda tend to marry and begin families earlier than men. Early marriage among girls often leads to early sexual initiation, while boys tend to delay marriage for economic or social reasons, contributing to a lower percentage of sexually active men in this age group.

3. **Access to Resources**: Girls may have more opportunities for early relationships and sexual activity through family or social connections, while boys may delay sexual activity due to fewer opportunities or social expectations to be financially stable before engaging in relationships.

4. **Sexual and Reproductive Health Education**: Both men and women in Uganda may face limited access to comprehensive sexuality education, but men may be more likely to avoid sexual relationships until they feel ready or have the financial means to support a partner or family.

In summary, cultural and religious norms and practices, marriage patterns, economic factors, and access to resources contribute to the higher percentage of men aged 20-24 who have never had sexual intercourse compared to women in the same age group in Uganda.

Table 7: Percentage of Men who have Never had sexual intercourse

UDHS Period		1995	2001	2006	2011	2016	2022
Age group	15-19	52.4	61.3	64.7	59.9	57.1	55.8
	20-24	11.2	12.5	13.8	14.5	11.6	9.8
	25-29	2.5	2.1	1.6	3.3	2.3	4.0
	30-34	0	0	0	1.1	1.6	0.9
	35-39	0.6	1	0.4	0.3	1.1	0.4
	40-44	0.3	0	0	0	0.1	1.2
	45-49	2.1	0	0	0	0.3	0.0

Source: Uganda Demographic and Health Survey

6.5 Sexual intercourse by exact age 15

Over the past decades, Uganda has experienced a notable decline in the percentage of both girls and boys initiating sexual intercourse by age 15 from 23.8 percent in 1995 to 10 percent in 2022 (Figure 4). Whereas this significant decline in the percentage of girls initiating sexual intercourse by age 15, surpasses the reduction observed among the boys, these trends suggest a general shift toward later sexual initiation among Ugandan youth (Figure 5).

There are several reasons why girls choose to indulge in sexual activity earlier in life. Some girls have initiated sexual activity for pleasure, need for material things, better grades, peer group influence, ignorance and others have been sexually abused by men who are many years older than them. This practice often comes with negative consequences on the girls who are not yet prepared for family roles as premarital sex can lead to teenage pregnancy, school dropout and STIs/HIV/AIDs. Some of the factors contributing to this trend include:

Educational Attainment: Higher education levels are associated with delayed sexual initiation. Female youth with secondary or higher education are less likely to engage in early sexual activity compared to those with no education.

Household Dynamics: The relationship to the household head significantly influences sexual initiation. Female youth who are children of the household head are less likely to engage in early sexual activity compared to those in other household relationships.

Media Exposure: Access to information through the media, such as newspapers, magazines, and the internet is linked to earlier sexual initiation among adolescents. This influence can be direct, through exposure to explicit material, such as pornography, or indirect, through shaping perceptions of sexuality and relationships. Social media platforms can normalize early sexual activity and portray it as a desirable or inevitable part of adolescence. Social media may also facilitate connections and relationships, sometimes leading to risky sexual encounters, including online solicitation and sexting.

On the other hand, the media may be a good information resource. Frequent use of newspapers or magazines has been associated with a lower likelihood of early sexual debut among female youth. Open conversations about sexuality, media literacy, and healthy relationships can also help adolescents navigate the influences of media.

Cultural and Regional Factors: Cultural norms and religious factors shape beliefs, values, and social norms surrounding sexuality, impacting when and how individuals engage in sexual activity. Some cultures may encourage early sexual activity, while others may discourage it, particularly before marriage. For example, residing in the Northern region has been linked to cultures that relate with a higher likelihood of early sexual debut among female youth.

Figure 4: First sexual intercourse by exact age 15 (Women), %

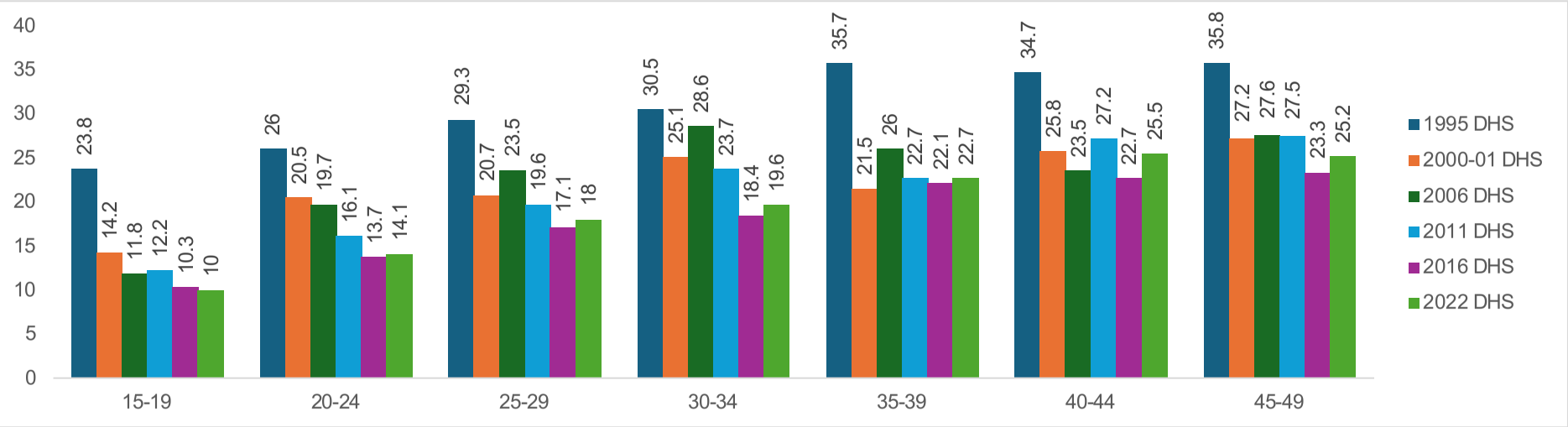
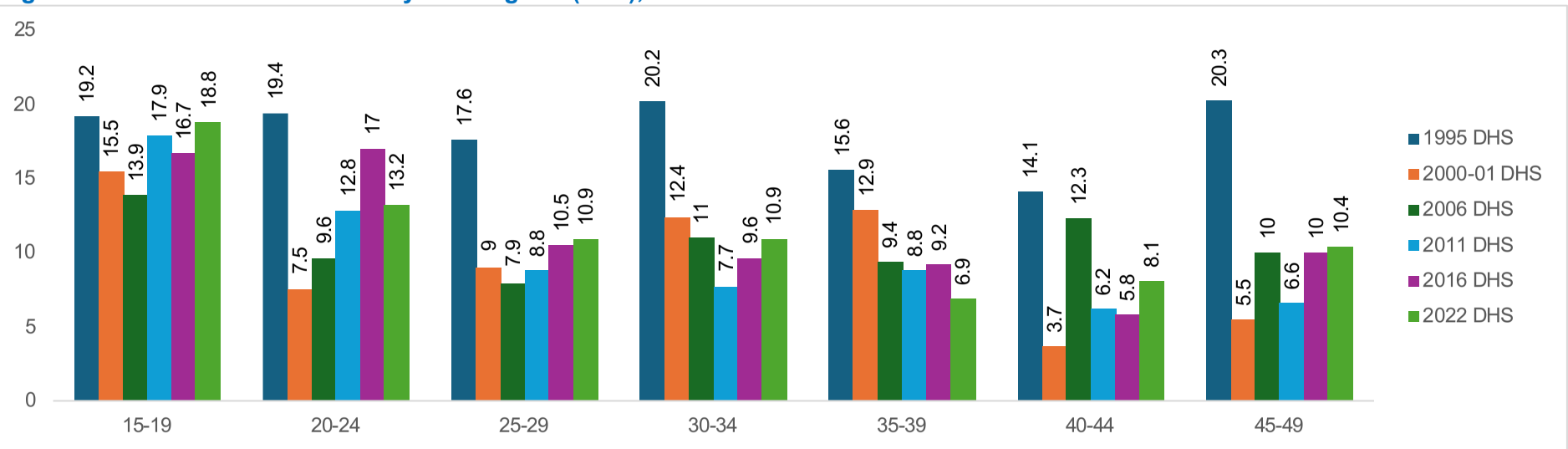


Figure 5: First sexual intercourse by exact age 15 (Men), %

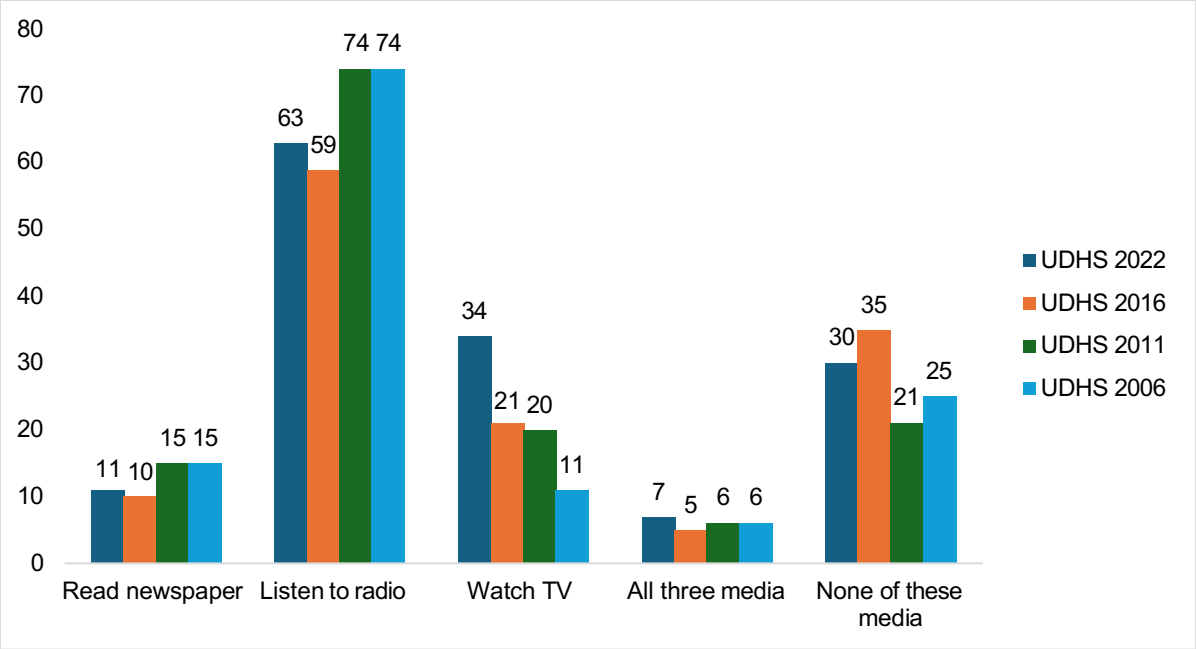


7. Awareness and exposure to FP messages

7.1 Exposure to mass media

Information about which women are likely to be reached by the media for diffusion of family planning, health and other important information is a useful indicator for program implementers. In Uganda, radio and television are more popular than printed materials, as seen from the Figure 6 below. The Figure below shows that the role of television and radio as communication media has become more significant due to low cost of the gargets and availability of new television and radio stations, therefore more women are getting exposed.

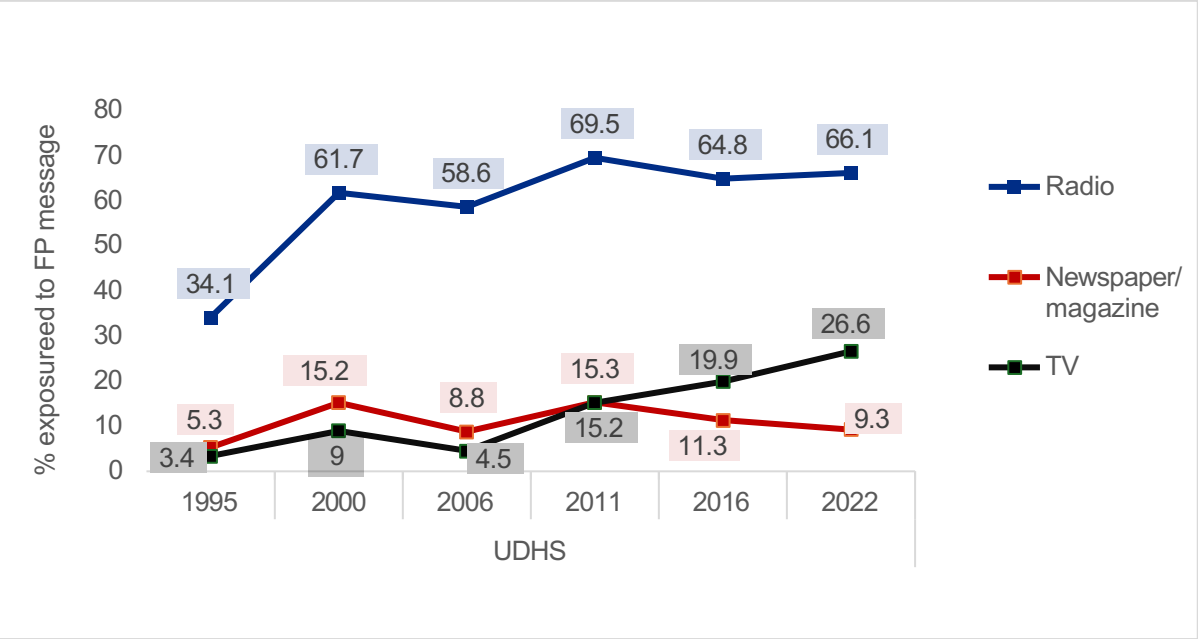
Figure 6: Percentage of women age 15-49 who are exposed to media on a weekly basis, %



7.2 Exposure to family planning message by radio [All Women]

As seen from Figure 7 below, between 1995 and 2022, radio has consistently been the most prevalent source of family planning messages for both women and men in Uganda compared to other media (newspaper/magazine, TV and mobile phone). This trend has remained stable over decades, with radio continuing to serve as the primary media for disseminating family planning information to the Ugandan population.

Figure 7: Exposure to family planning messages



This kind of trend can be explained by the following reasons among others;

Widespread Accessibility: Radio has a broad reach, even in rural and remote areas where other forms of media like television or the magazine may not be accessible. Many Ugandans, both men and women, particularly in rural areas, own radios or can easily access them through public spaces like markets, villages, and gatherings.

Cost-Effective: Compared to other forms of media like television or print media, radio is more affordable for both the producers of family planning messages and the general population. This makes it a practical tool for disseminating information to a large audience, including those with lower incomes.

Language and Local Adaptation: Radio stations in Uganda often broadcast in multiple languages and dialects, making family planning messages more relevant and accessible to diverse communities. This localized approach ensures that the messages resonate better and are understood by the audience.

Engagement and Interaction: Radio programs often encourage interaction through call-ins, allowing listeners to ask questions or share experiences. This interactive format fosters a deeper connection with the audience, making it a trusted source for health information, including family planning.

Together, these factors make radio a dominant and efficient channel for family planning education in Uganda, especially in the context of reaching diverse and rural populations.

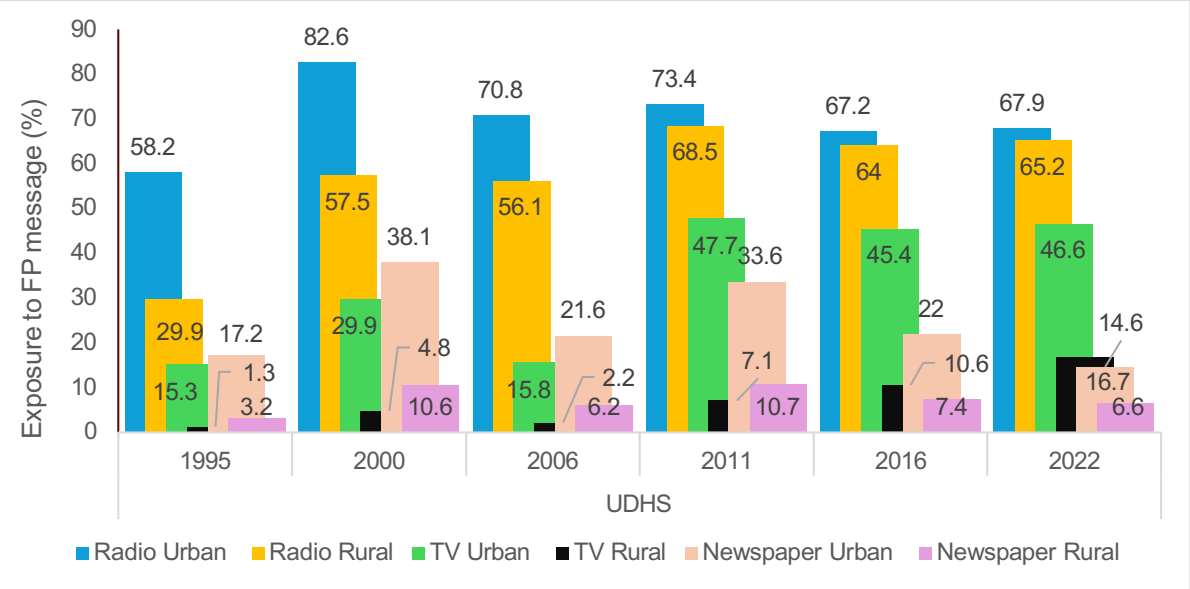
7.3 Exposure to family planning messages by residence

Exposure to family planning messages has generally been higher in urban areas than in rural areas of Uganda. This trend is highlighted in various Uganda Demographic and Health Surveys (UDHS) reports.

In urban areas, there is greater access to multiple sources of media such as radio, television, the internet, and print, making it easier for residents to encounter family planning messages through these channels. Additionally, urban populations tend to have higher literacy rates and better access to health services, further increasing exposure to family planning information. In contrast, rural areas often face challenges such as limited access to media, lower literacy levels, and fewer health resources, which result in reduced exposure to family planning messages. However, radio remains a powerful tool in both urban and rural settings, though overall media exposure is typically higher in urban areas.

Over the years, there have been a narrowing gap between access to information through the radio channels in both urban and rural areas (Figure 8).

Figure 8: Exposure to family planning messages by residence



7.4 Exposure to family planning messages by Education Level

In terms of education, for decades, exposure to family planning messages in Uganda is significantly higher among individuals with higher education compared to those with lower or no education (Table.8). Individuals with higher education levels are more likely to engage with various media, including radio, television, and the internet, which increases their exposure to family planning information.

They also tend to have better health literacy, making them more receptive to such messages. In contrast, those with lower or no education may have limited access to media and may not fully comprehend the importance of family planning, resulting in lower exposure to such messages.

Table 8: Exposure to family planning messages by Education Level

Communication media	Education Level	UDHS					
		1995	2000	2006	2011	2016	2022
Radio	No education	16.1	44.4	45.3	54.2	53.1	46
	Primary	36.4	61.6	58.4	68.6	61.8	64.8
	Secondary	65.3	81.6	69.9	77.6	73.4	73.1
	Higher	96.4	88.2	77.8	81.8	74.2	76.9
Television (TV)	No education	0.1	2.7	0.3	2.8	5.0	8.7
	Primary	2.2	5.8	2.0	8.6	10.7	17.2
	Secondary	15	23.9	12.9	30	34.7	44.6
	Higher	65.6	41	25.1	56.4	58.3	60.2
Newspaper/ magazine	No education	0.2	3.1	0.5	2.2	1.5	1.4
	Primary	3.4	10.1	4.3	7.9	4.4	4.2
	Secondary	24.5	42	24.8	31.6	21.1	17.1
	Higher	56.3	68	46.5	60.5	42.2	34

The high exposure to family planning messages among individuals with higher education levels in Uganda, as reflected in the above UDHS trends, can be explained by several factors among others:

1. **Increased Media Access**: Educated individuals are more likely to have access to various media platforms such as radio, television, and newspaper/magazine, which are key sources of family planning information.

2. **Better Information Seeking Behaviour**: Educated individuals are more likely to actively search for and consume health-related information, including family planning, compared to those with no or lower education levels.

3. **Higher Health Literacy**: Those with higher education tend to have better understanding and awareness of health issues, making them more likely to engage with and seek out family planning messages.

4. **Social Economic Factors**: Higher education is often associated with improved socio-economic status, which provides more opportunities for accessing diverse sources of information and services, thus increasing exposure to family planning messages.

These factors among others collectively explain the higher exposure to family planning messages among individuals with higher education levels in Uganda.

7.5 Exposure to family planning messages by Wealth Index

According to Uganda Demographic and Health Surveys (UDHS) trends, exposure to family planning messages through all media is higher among individuals in higher wealth index categories compared to those in the lowest wealth index (Table.9).

Table 9: Exposure to family planning messages by Wealth index

Communication media	Education Level	UDHS					
		1995	2000	2006	2011	2016	2022
Radio	Lowest	10.2	33.6	35.1	52.8	49	51.7
	Second	20.2	46.5	50.8	65.8	61.3	63.3
	Middle	32.2	62.6	58.7	72.7	69.1	69.2
	Fourth	44	75	68.9	75.8	72	73.2
	Highest	62.2	84.8	73.8	76.1	69.6	70.6
Television (TV)	Lowest	0.1	1.3	0.2	1.2	2.2	3.5
	Second	1.2	1.4	0.8	2.6	4.1	6.7
	Middle	0.5	3.3	1.0	3.6	7.0	12.3
	Fourth	0.6	5.3	2.5	8.6	13.4	29.4
	Highest	13.3	28.8	14.5	46.8	58	66.8
Newspaper/ magazine	Lowest	0.3	3.1	1.0	4.3	2.8	2.3
	Second	1.8	4.6	2.6	6.3	4.4	4.1
	Middle	2.4	8.6	4.1	7.3	5.2	6.2
	Fourth	3.8	14.9	8.1	14.1	10.8	10
	Highest	16.9	38.9	23.4	35.7	26.9	19.8

This kind of trend can be explained by the following factors:

5. **Greater Media Access**: People in higher wealth categories have better access to media platforms such as television, radio, and are able to afford the internet, which are key sources for family planning messages.

6. **Improved Communication Infrastructure**: Higher wealth often correlates with better access to technology and services, such as electricity, mobile phones and internet services, allowing for broader exposure to family planning information.

7. **Higher Education and Health Literacy**: Wealthier individuals tend to have higher education levels, which enhances their ability to understand and seek out family planning information. Education in addition empowers individuals to make informed decisions, and can lead to greater economic opportunities, which in turn can influence family size preferences.

8. **Social and Economic Opportunities**: Wealthier individuals are more likely to utilize contraception. This is often attributed to the ability to afford services, transportation to facilities, and increased access to information. Conversely, individuals with lower socioeconomic status may face barriers to access, including cost, distance to facilities, and lack of awareness.

These factors among others contribute to higher exposure to family planning messages among individuals with higher wealth compared to those in the lowest wealth index.

7.6 Exposure to Family Planning Messages by Age

Generally, contraceptive use tends to increase with age, peaking in the 35-49 age group. However, younger women may face unique barriers and require tailored family planning strategies. Over time, exposure to family planning messages through all media has had an increasing trend as women age from 15 to 19 years and continues to rise in subsequent age groups (Table.10). This is because, as women grow older, they have more access to media, greater health awareness, and more life experience, making them more likely to engage with family planning information. However, exposure begins to decline as women approach the end of their reproductive years. This drop can be attributed to factors such as reduced fertility concerns as women age, less engagement with family planning media, and changes in their health priorities. Additionally, women in older age groups may have fewer children or may no longer be actively seeking family planning information, contributing to lower media exposure towards the end of their reproductive age.

Table 10: exposure to family planning messages by Age

Communication medium	Age	UDHS					
		1995	2000	2006	2011	2016	2022
Radio	15-19	32	57	51.7	61.1	57.2	56.6
	20-24	35.7	63.4	59.6	74.7	67.4	68.1
	25-29	35.5	66.2	63.6	72	67.9	69
	30-34	36.7	65.6	61.2	72.1	67.5	71.7
	35-39	34.5	57.6	60.9	70.4	66.3	68.1
	40-44	31.1	62.9	58.4	71.1	66.4	66.9
	45-49	28.5	56.8	57.9	68.6	65.9	67.5
Television (TV)	15-19	3.6	10.4	5.2	14.9	16.8	21.8
	20-24	3.8	9.8	5.5	19.1	23.9	29.8
	25-29	4.2	9.5	4.8	16.4	24.7	31.3
	30-34	3.3	7.3	3.9	16.9	20.4	30.8
	35-39	2.1	7.4	3.4	10.7	17.6	25.4
	40-44	2.3	7.5	3.1	10.9	15.9	23
	45-49	2	7.6	2.8	11.9	14.3	20.9

Communication medium	Age	UDHS					
		1995	2000	2006	2011	2016	2022
Newspaper/ magazine	15-19	5.6	17.2	11.4	18.4	11	8.9
	20-24	5.4	16	10.7	18.1	12.6	9.9
	25-29	5.7	15.9	8.7	13.8	13.5	10.6
	30-34	6.2	15.8	7.3	13.8	11.1	10.3
	35-39	4.9	12.3	6.9	12.2	10	9.2
	40-44	3.8	12.9	5.3	12.2	8.9	7.8
	45-49	2.6	10	5.5	12.2	8.2	5.9

7 Postpartum Insusceptibility

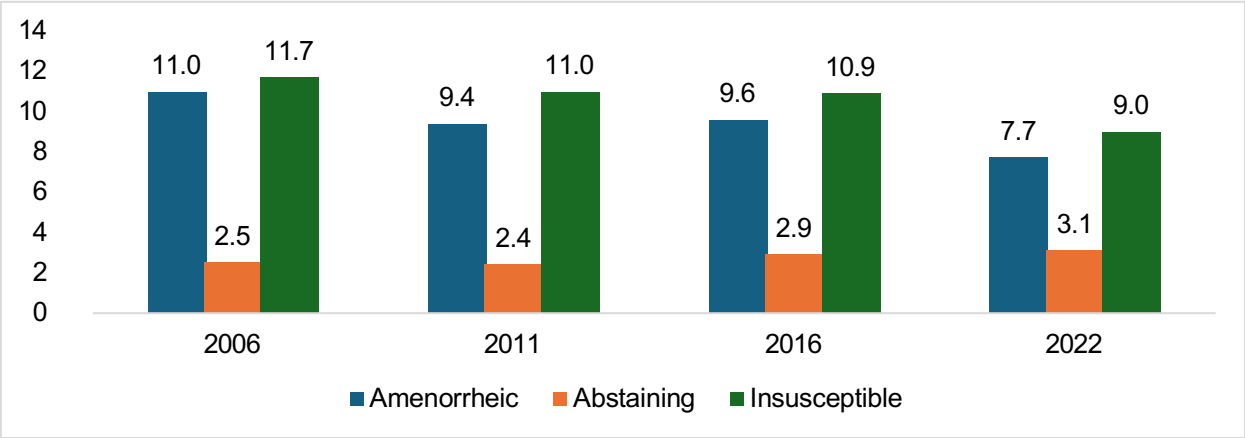
Postpartum insusceptibility: The period during which a woman is considered not at risk of pregnancy either because she is postpartum amenorrhoeic and/or abstaining from sexual intercourse postpartum.

a) **Postpartum amenorrhea:** The period after the birth of a child and before the resumption of menstruation.

b) **Postpartum abstinence:** The period after the birth of a child and before the resumption of sexual intercourse.

The duration and intensity of breastfeeding and postpartum abstinence can significantly influence the time until a woman becomes fertile again. During the period of postpartum insusceptibility, contraceptive use is often redundant because behaviours around breastfeeding and abstinence are already preventing pregnancy. Figure 9 shows a reduction in the median duration of postpartum amenorrhea and insusceptibility while the duration for abstinence has increased overtime.

Figure 9: Median duration of postpartum amenorrhea, abstinence and insusceptibility for births



Source: Uganda Demographic and Health Survey

8 Mean number of children ever born (CEB)

Table 11 shows that the overall mean number of children ever born (CEB) did not steadily decrease in the early surveys. It ranged from 3.49 in 1988/89 to attain the highest figure at 3.53 in the 2006 survey. However, a substantial and steady decline has been observed in the subsequent surveys, dropping by about 21 percent from 3.53 (2006) to 2.79 (2022). The mean number of CEB among the 15-19 olds has been consistently high~ 0.23 from 2006, but the earlier surveys registered a higher average 0.39 (1988/89), 0.45 (1995) and 0.33 (2000/01). Across all the years except for the 15–19-year-olds, CEB had been declining until 2000/01 when an increase was observed, but then steadily decreased during the subsequent surveys. The apparent increase in 2000/01 may have been effects of fertility behaviors or FP services delivery in the preceding 5-years before the 2001/01 survey.

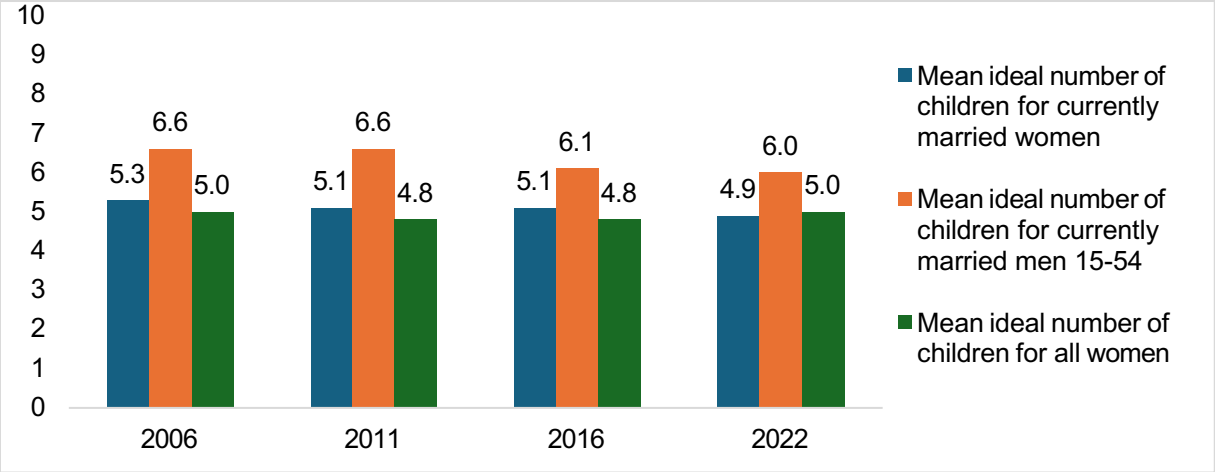
Table 11: Mean number of children ever born and are living

Age group	1988-89 UDHS	1995 UDHS	2000-01 UDHS	2006 UDHS	2011 UDHS	2016 UDHS	2022 UDHS
15-19	0.39	0.45	0.33	0.23	0.24	0.23	0.2
20-24	1.86	1.83	1.93	1.71	1.6	1.43	1.27
25-29	3.65	3.34	3.41	3.51	3.34	2.85	2.51
30-34	5.04	5.06	5.02	5.16	4.97	4.35	3.79
35-39	6.79	6.29	6.05	6.31	6.27	5.82	4.91
40-44	7.24	6.97	6.93	6.99	7.13	6.55	5.66
45-49	7.77	7.69	7.37	7.73	7.36	7.09	5.91
Total	**3.49**	**3.41**	**3.44**	**3.53**	**3.42**	**3.08**	**2.79**
Mean ideal number of children (45-49)	7.5	7.0	6.4	6.7	6.2	6.3	6.5

9 Mean Ideal Number of Children

The ideal number of children is often considered as a proxy measure of fertility, especially for individuals who have not yet completed their fertility. The mean ideal number of children is determined from the question about Ideal family size. Respondents with no children are asked "If you could choose exactly the number of children to have in your whole life, how many would that be?" Respondents who had children were asked "If you could go back to the time before you got children, how many children would you have in your whole life?". Figure 10 shows a decrease in the mean ideal number of children among women generally from 2006 to 2022. 2022, however, registered a slight increase in ideal number of children for all women by 0.2 percent.

Figure 10: Mean Ideal number of children



Source: Uganda Demographic and Health Survey

In this analysis (Table 12) we focused on women 45-49 years who are likely to have completed their fertility. The mean ideal number of children (MINC) among the 45–49-year-olds was compared to the achieved mean CEB. The MINC has declined from 6.7(2006) to 6.5 (2022). However, it is only in 2022 where the mean ideal number, 6.5 was higher than mean CEB, 5.91 achieved by women completing childbearing (45-49). These data suggest a decline in desire and that women seem to start achieving their desires; this again may be associated with improved FP service availability.

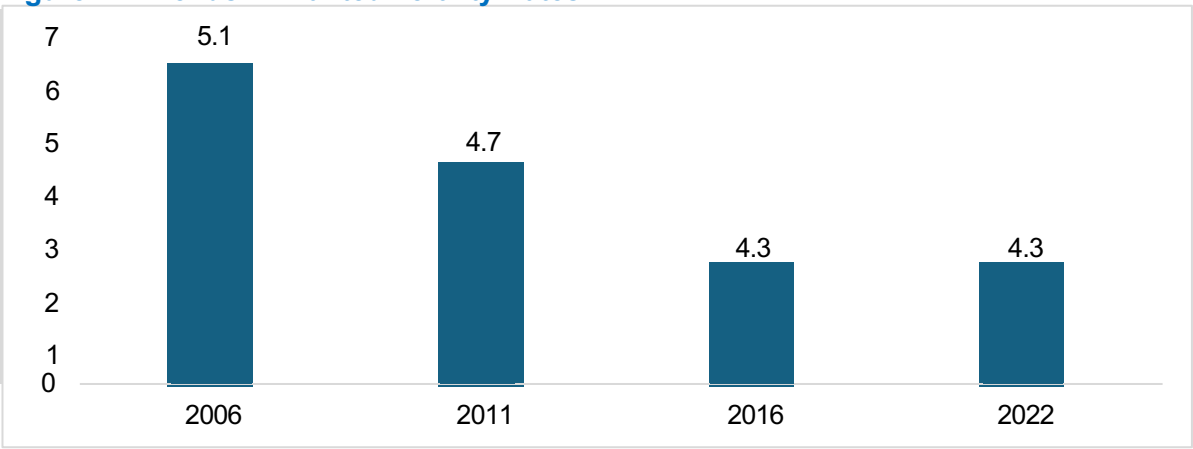
Table 12: Mean ideal number of children (All women)

Characteristic		1988-89 UDHS	1995 UDHS	2000-01 UDHS	2006 UDHS	2011 UDHS	2016 UDHS	2022 UDHS
	Total	6.5	5.3	4.8	5.0	4.8	4.8	5.0
Residence	Urban	5.5	4.2	3.8	4.0	4.1	4.3	4.6
	Rural	6.6	5.5	5.1	5.2	5.0	5.0	5.2
Highest education attained	No education	7.2	6.3	5.9	6.1	6.2	6.3	5.8
	Primary	6.3	5.1	4.8	5.0	4.9	4.9	5.2
	Secondary	5.2	4.0	3.8	4.1	4.0	4.2	4.4
	Higher	NA	2.8	3.6	3.7	3.7	4.0	4.2
Wealth quintile	Lowest	NA	5.9	5.5	5.5	5.5	5.3	5.3
	Second	NA	5.6	5.3	5.3	4.9	5.0	5.2
	Middle	NA	5.4	5.1	5.3	4.9	5.0	5.1
	Fourth	NA	5.3	4.8	5.1	4.9	4.8	4.9
	Highest	NA	4.4	3.9	4.0	4.2	4.2	4.5
Age group	15-19	5.9	4.4	4.1	4.1	4.1	4.1	4.2
	20-24	6.1	4.8	4.3	4.3	4.3	4.2	4.4
	25-29	6.5	5.1	4.8	4.9	4.7	4.6	4.8
	30-34	6.8	5.9	5.2	5.4	5.1	5.1	5.2
	35-39	7.1	6.2	5.5	5.7	5.6	5.6	5.6
	40-44	7.4	6.6	5.9	6.0	6.0	5.9	6.0
	45-49	7.5	7.0	6.4	6.7	6.2	6.3	6.5

10 Wanted Fertility

The "wanted fertility rate" measures the number of births that would occur if only wanted births happened. Family planning programs aim to help individuals achieve their desired family size by providing access to contraception and reproductive health services. Figure 11 shows that the wanted fertility rate is an average of 4.3 children; a decline overtime from 5.1 children registered in 2006.

Figure 11: Trends in Wanted Fertility Rates

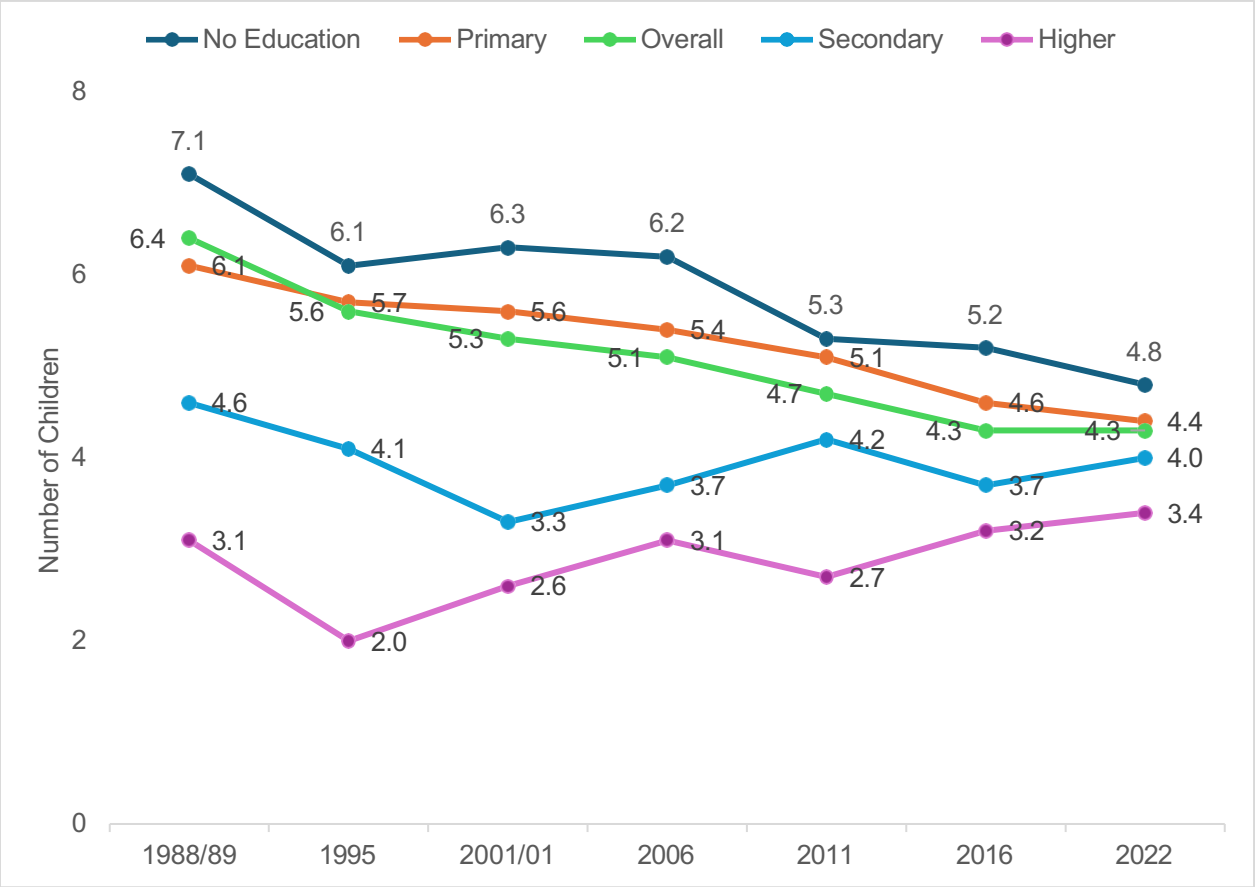


Source: Uganda Demographic and Health Survey

Figure 12 shows trends in the wanted fertility by women's level of education. We also assessed wanted fertility, defined as the average number of children a woman would have by the end of her childbearing years if she bore children at the current age-specific fertility rates, excluding unwanted births. The wanted fertility rate therefore reflects the level of fertility that would result if all unwanted births were prevented. Overall wanted fertility has declined from 6.4 (1988/89) to 4.3 (2022).

Wanted fertility is highest among women with no education followed by those with primary education. The two education levels have experienced a steady decline. Wanted fertility is lower among women with secondary and lowest for women with higher education. However, compared to women with primary or no education, wanted fertility has been increasing for women in secondary or higher education since the 2011 UDHS.

Figure 12: Trends in the wanted fertility by women's level of education



Source: Uganda Demographic and Health Survey

11 Desire for children

A desire for more children is a common phenomenon, influenced by factors like strong preferences for large family sizes, cultural norms, and socioeconomic conditions. Access to and participation in family planning programs can help individuals make informed decisions about family size and when to have children.

Table 13 shows that overtime, the desire for more children has increased with 32.2 percent of women aged 15-49 saying they want no more children in 2022; a decrease from 38.6 percent registered in 2006.

Table 13: Desire for children among women aged 15-49

Family Planning Status	1988-89 UDHS	1995 UDHS	2000-01 UDHS	2006 UDHS	2011 UDHS	2016 UDHS	2022 UDHS
Have another soon	38.6	23.3	18.5	16.2	14.3	14.7	14.5
Have another later	33.4	36.3	34.7	35.3	37.8	40.2	40.3
Wants, unsure timing	2.0	1.2	1.4	1.2	0.8	2.0	0.7
Undecided	3.1	3.6	3.6	3.8	2.7	3.0	6.9
Wants no more	19.4	30.9	36.4	38.6	39.5	35.1	32.2
Sterilized	3.4	1.4	2.0	2.5	3.0	2.8	2.8
Declared infecund	NA	3.3	3.1	2.3	1.8	2.3	2.6

Table 14 shows that overtime, the desire for no more children increases with parity from 1.7 percent of women aged 15-49 with one child saying they want no more children in 2022 to 12 percent among those with more than three children.

Table 14: Family Planning Status by birth order

Family Planning Status	Birth Order	1995 UDHS	2000-1 UDHS	2006 UDHS	2011 UDHS	2016 UDHS	2022 UDHS
Wanted then	1	79.5	70.7	58.3	63.3	61.9	64.8
	2	71.7	64.6	54.7	64.2	64.8	71.5
	3	72.1	58.2	43.5	59.8	64.4	71.5
	4+	62.8	48.5	35.2	43.7	52.1	62.7
Wanted later	1	19.0	20.1	33.5	35.0	36.5	33.5
	2	26.7	28.8	38.7	33.6	34	27.4
	3	25.3	34.8	40.8	38.2	32.8	27.1
	4+	21.8	28.2	33.3	33.6	28.7	25.4
Wanted no more	1	1.4	9.0	4.2	1.3	1.6	1.7
	2	1.2	6.4	3.0	2.0	1.2	1.1
	3	2.5	6.7	4.8	2.0	2.7	1.4
	4+	15.3	23.2	23.2	22.5	19.2	12.0

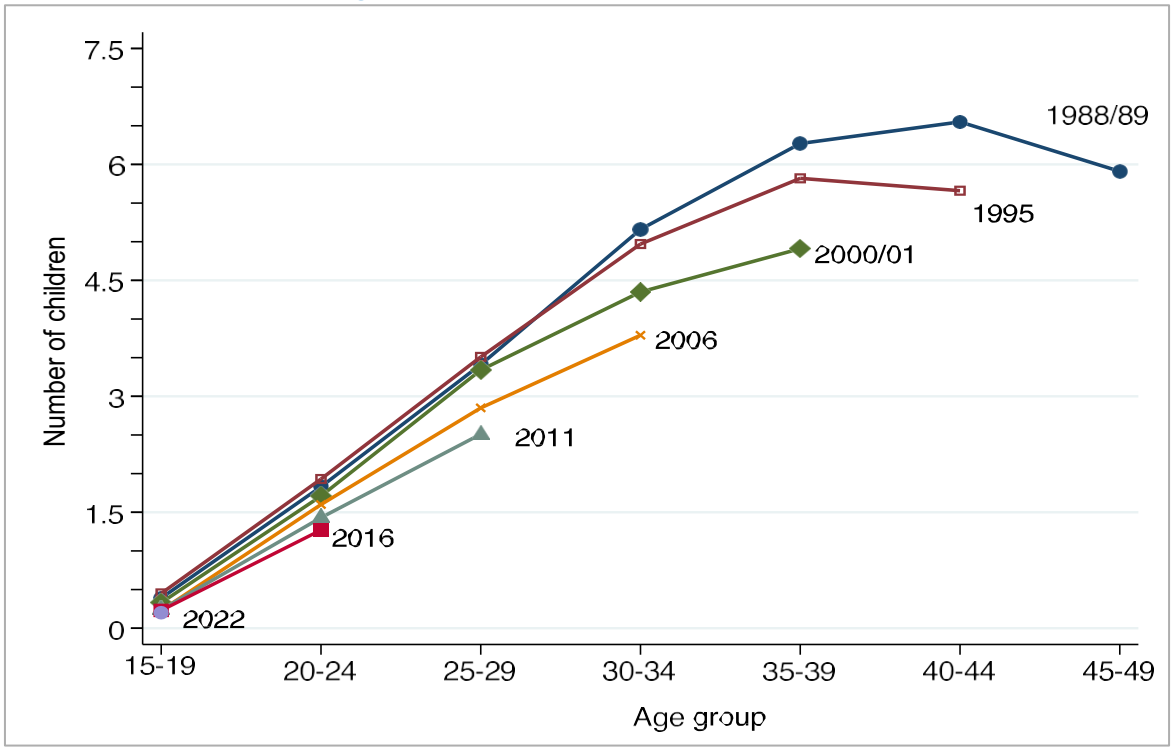
12 Synthetic cohorts of 15-19 women at each DHS

The 15-19 women cohorts tracked over the subsequent surveys as they age in five-year age bands, seem to indicate that later 15-19 cohorts consistently and steadily tend to have lower mean of CEB as they age suggesting a decline in fertility. For example, 15-19 year-1995 DHS cohorts mean CEB of 0.45, while their counter parts in 2000/01 DHS cohorts have 0.33. The subsequent DHS when both cohorts were aged 20-24, the mean CEB was 1.93 (1995 UDHS 15-19 cohort) while 1.71 (2000/01 UDHS 15-19 cohort). So, across the 20-24 age years per DHS, each of the 15-19 DHS cohorts experienced lower mean CEB.

Figure 13 further shows the trends in the average number of CEB by cohort of adolescents15 19 at each DHS. Although we observe a potential cohort, the period-effect when government policies such as universal Primary/Secondary education were introduced, but also availability and uptake of FP services increased at the same time.

These data also indicate the importance of engaging adolescents and young people with appropriate information and services if a decline in fertility especially unintended pregnancies can be achieved. So social norms and early involvement of young people in sexual reproductive health services including information and policies that keep young people in schools or skills development settings may be a good strategy.

Figure 13: Trends in the average number of Children ever born (CEB) and are living by Cohorts of adolescents aged 15_19 at each DHS



Source: Uganda Demographic and Health Survey

13 Teenage Childbearing

Teenage childbearing determined as proportion of 15–19-year-olds who had started childbearing was 23.5 percent and this has not changed since UDHS 2006 to 2022. This followed high declining rates in the 3 earlier DHS years, 37.2 percent (1988/89), 42.9 percent (1995) and 31.4 percent (2000/01) as shown in Figure 14.

The percentage of teenagers with first-time pregnancy has not changed either. The 2000/01 decline coincided with the introduction of Universal Primary and Secondary education policies. However, the availability of SRH services also expanded with various implementing partners supporting services including outreaches to ensure no one is left behind. However, the stagnation may suggest further identification of the subgroups that may not be reached by the expanded services.

An analysis of equity in FP services including information as well as analysis of disparity in teenage childbearing across dimensions of equity (geography-rural/urban, region/sub-region, wealth, and education). These approaches may help identifying which teenagers are not reached and why provide appropriate interventions to close these gaps.

Figure 14: Percent of Teenagers who have begun childbearing

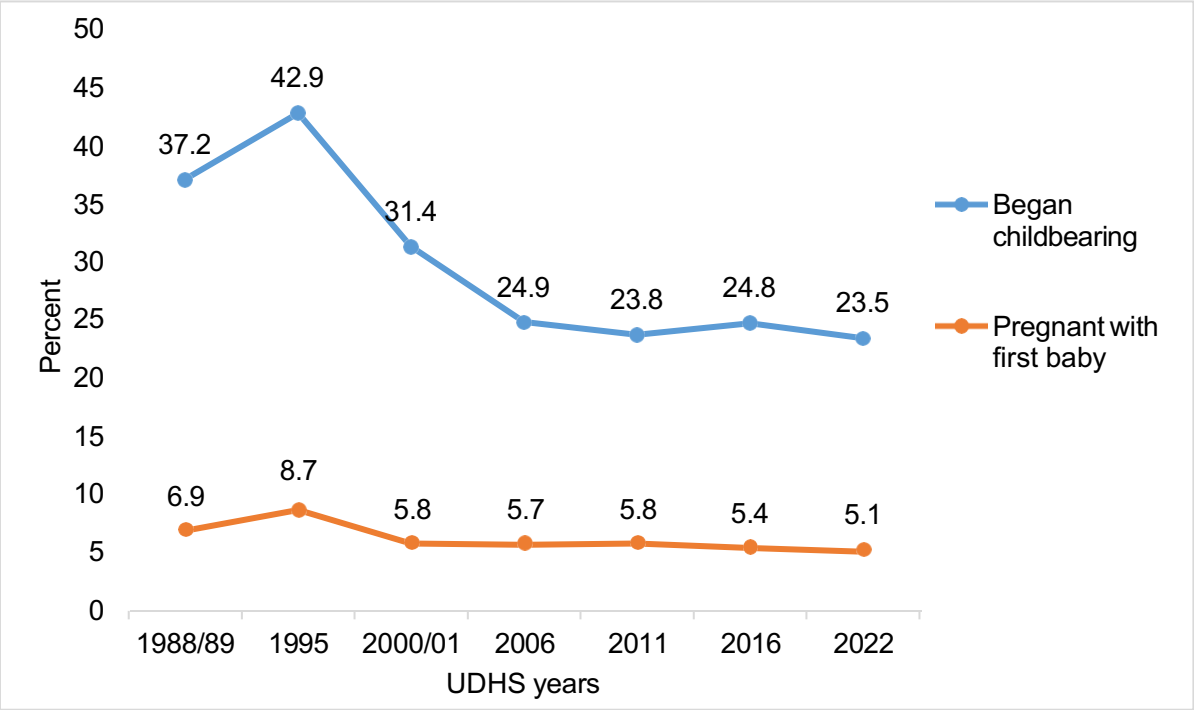


Table 15 shows that there are more cases of teenage pregnancy recorded compared to the urban, which have consistently had higher percent of teenage childbearing, but the difference has been decreasing suggesting improving equality or equity in services or effects of the Uganda social policies like UPE and USE. The education context is shown by the closing gap between the no-education and those with primary education; the gap has dropped from high of 26-point difference in 2000/01 to just 0.6 -points in 2022. Improving children's enrolment in school, especially among primary education appears a good policy and strategy to address teenage childbearing. Overall, after age 16 years, when children cross over to upper secondary, the percentage of teenage childbearing also increases. Keeping children enrolled in school even after lower senior level (O-level) may be an important strategy to further minimize teenage childbearing.

Table 15: Percent of Teenagers who have begun childbearing

Overall	**1995**	**2000-01**	**2006**	**2011**	**2016**	**2022**
	42.9	**31.4**	**24.9**	**23.8**	**24.8**	**23.5**
Residence						
Urban	30.6	22.5	19.7	21.4	18.8	20.5
Rural	45.4	33.6	26.0	24.4	26.7	24.9
Education						
No education	48.5	59.0	50.2	44.5	34.6	27.1
Primary	47.3	33.1	27.9	26.9	28.7	26.5
Secondary	18.7	16.7	15.7	16	17	17.4
Higher	N/A	N/A	5.6	11.9	11	7.5
Wealth quintile						
Lowest	48.8	47.5	40.7	34.4	33.5	33.3
Second	49.3	40.8	31.2	32.8	31.9	27.9
Middle	44.8	31.2	22.2	24.3	24.6	23.8
Fourth	42.4	23.7	22.6	19.1	21.5	20.6
Highest	31.5	20.2	16.3	15.8	15.1	15.3
Age						
15-17	11.1	9.5	10.8	13.2	24.1	10
15	3.1	1.6	1.9	3.3	7.7	3.3
16	9.4	8.5	8.5	12.9	22.1	8.5
17	22.1	20.8	25.5	23.2	43.3	20.1
18	40.2	37.4	41.0	54.0	64.7	36.8
19	53.9	57.6	58.6	61.2	70.8	55.5

Source: Uganda Demographic and Health Survey

14 Trends in Fertility Planning status

Figure 15 shows the trends in Fertility Planning status. Planning status of births/current pregnancies was assessed by asking women whether their births in the 3 years before the survey or current pregnancies were wanted at the time (planned birth), wanted at a later time (mistimed birth), or not wanted at all (unwanted birth).

The percent of women who wanted no-more children was highest in 2000/01 at 15.1 percent and steadily declined to 6 percent in 2022. However, women with mistimed births remains at 27.7 percent in 2022, but this followed a persistently high level at 35 percent for the three preceding DHS (2006, 2011 and 2016). The decline in no-more may suggest improved FP service availability, but the 6 percent in 2022 remains of concern so is the mistimed births. The fertility planning status significantly varied by women's age. Women aged 40-44, and 45-49 years mostly experienced unwanted births/pregnancies (no more) and were limiters. The challenges of unwanted births/pregnancies in this age group have persisted and were highest in DHS2011. A higher percent of women aged 39 years or younger mainly experienced mistimed births/pregnancies, and this was commonest in women aged 29 years or younger.

Figure 15: Trends in Fertility Planning status

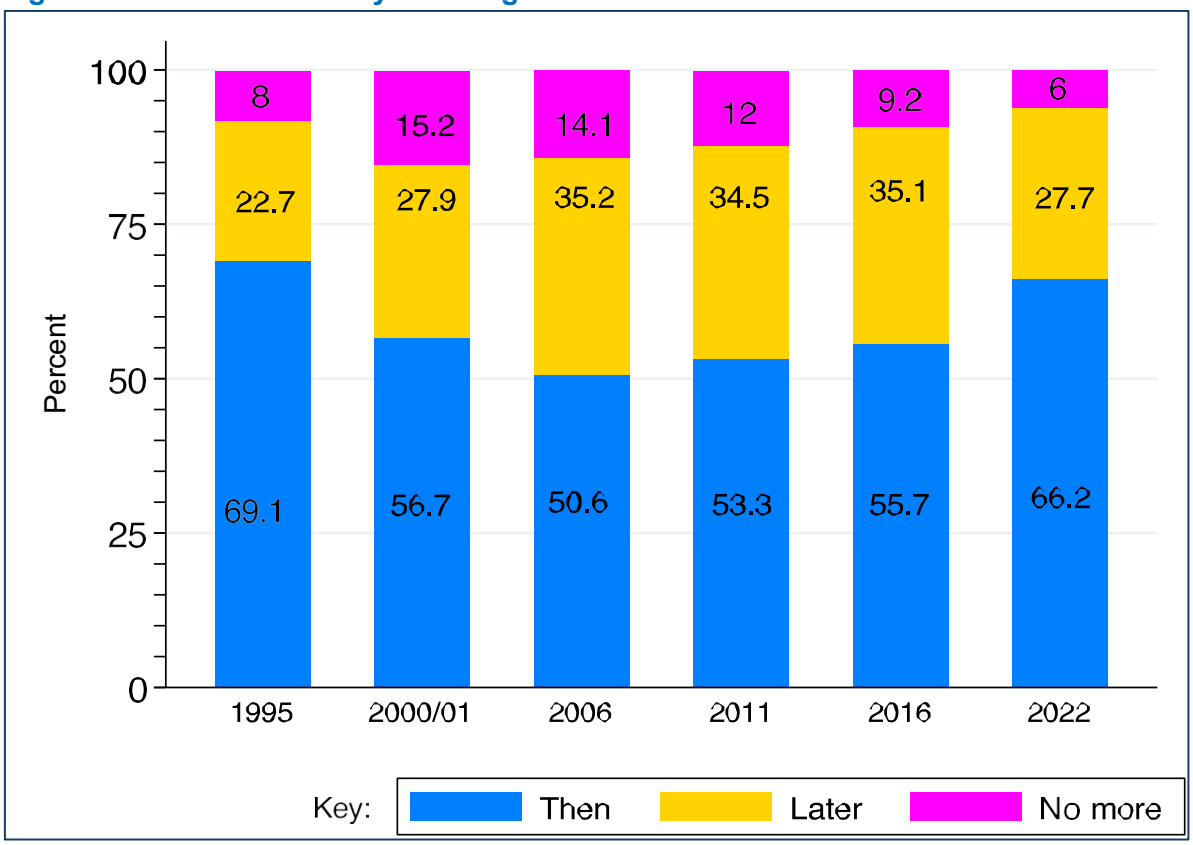
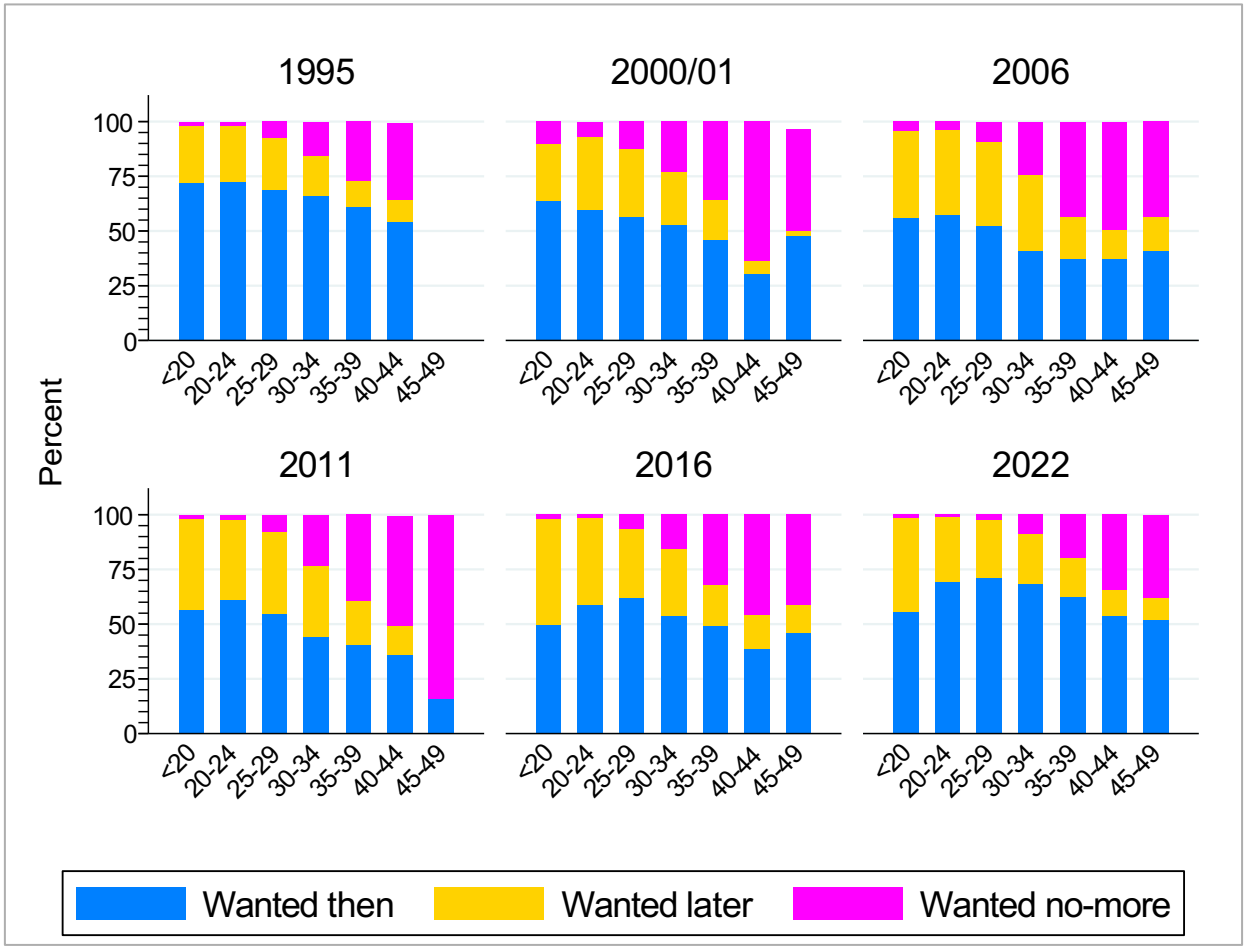


Figure 16 shows that although young women who have mistimed births/pregnancies remains an important challenge older women who are limiters remain at increased risk of having births/pregnancy when they wanted no-more.

Figure 16: Trends in Fertility Planning status by age category



Figures 17 and 18 show trends in discussion of FP among non-users of FP at Health facility or Village Health Teams (VHT) visiting homes. Nonusers of FP at time of the surveys were asked about the contact with family planning providers and if they discussed FP with a field worker (VHT/CHW) or during a visit to a health facility in the 12 months before the survey. Contact with FP providers has been increasing over the six DHS for both fieldworkers and at the health facility visits, consistently higher at the health facility than fieldworkers. Contact at health facility was steadier than fieldwork contacts.

In the stratified analysis, women in the rural areas tended to report higher contacts with FP providers compared to the urban, irrespective of the source, fieldworker or health facility. Rural over urban positive difference was observed in 2006 while for the fieldworkers was in 2016. These findings suggest intensifying FP discussions at both facilities and amongst fieldworkers, as IPs continue to support FP services and information including outreaches.

Figure 17: Overall trends in discussion of FP among non-users of FP at Health facility or VHT visiting home

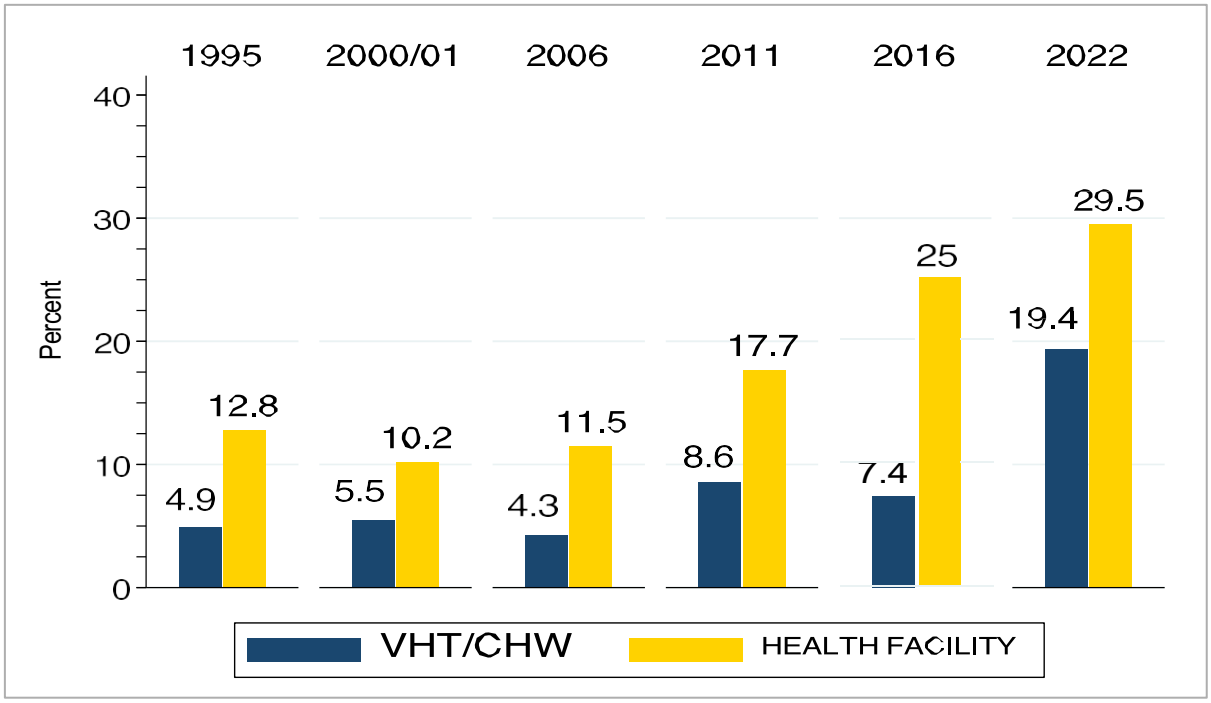
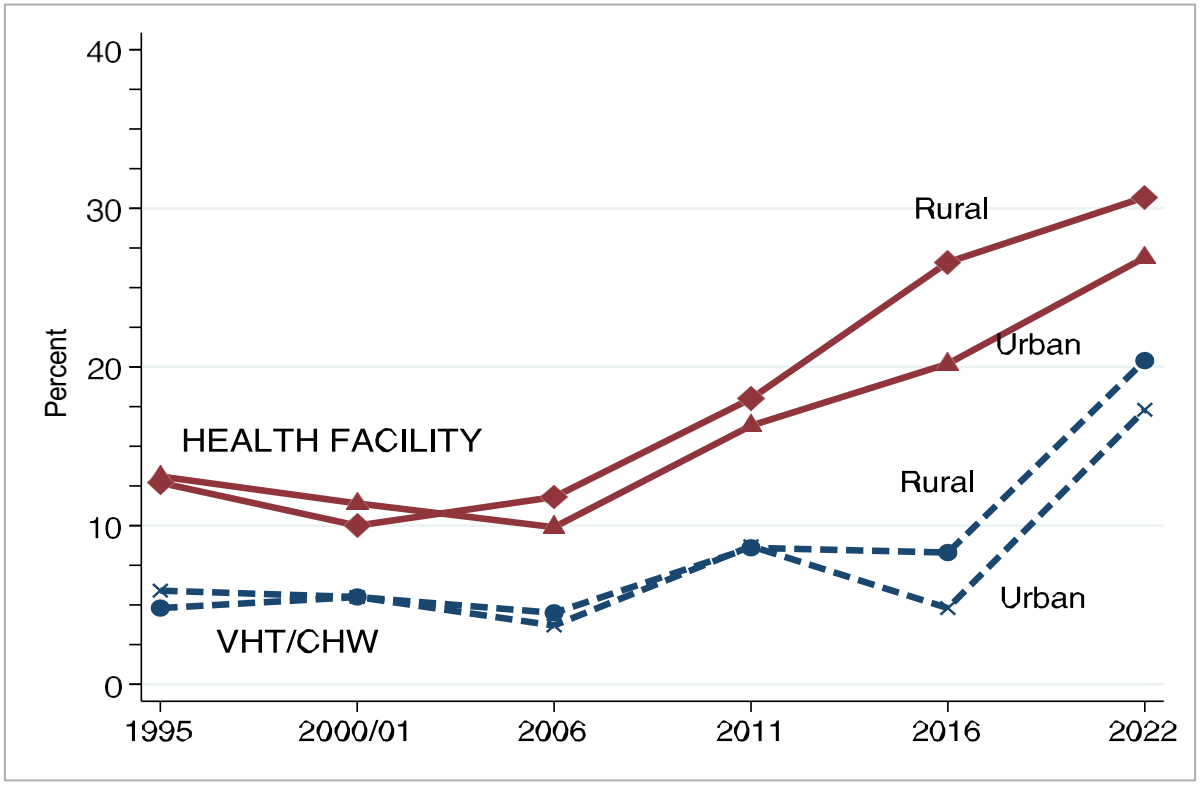


Figure 18: Trends in discussion of FP among nonusers of FP at Health facility or VHT visiting home by rural-urban residence



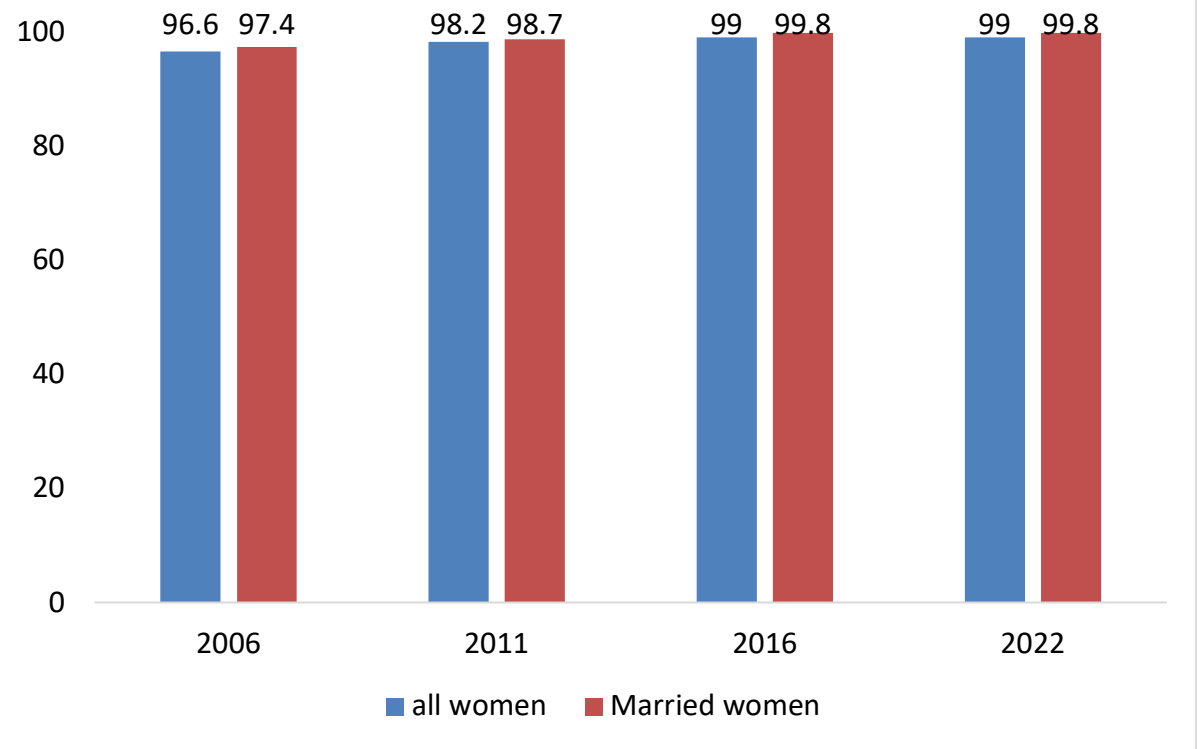
15 Contraception and Contraceptive Use

15.6 Knowledge of any method of contraceptive method

Information on knowledge of, attitude about, and practice of contraception is of particular interest to policy makers, program managers, and researchers. Familiarity with contraceptive methods is among the prerequisites for the adoption of fertility regulation. Information about contraceptive methods has been disseminated through various channels since the initiation of the national family planning programs in Uganda in 1950s, with the first Family Planning Association of Uganda (FPAU) clinic, now Reproductive Health Uganda (RHU) opening in 1957.

Increasing public awareness about family planning and maternal and child health (MCH) services is important and healthcare providers play a key role in providing information and education about family planning. Knowledge of at least some contraceptive methods has been widespread in Uganda. Most women who know of a contraceptive method know a modern method and virtually all currently married women also know where to go to obtain a family planning method. Figure 19 shows that knowledge of contraceptive use has increased overtime and is almost universal.

Figure 19: Knowledge of any contraceptive method



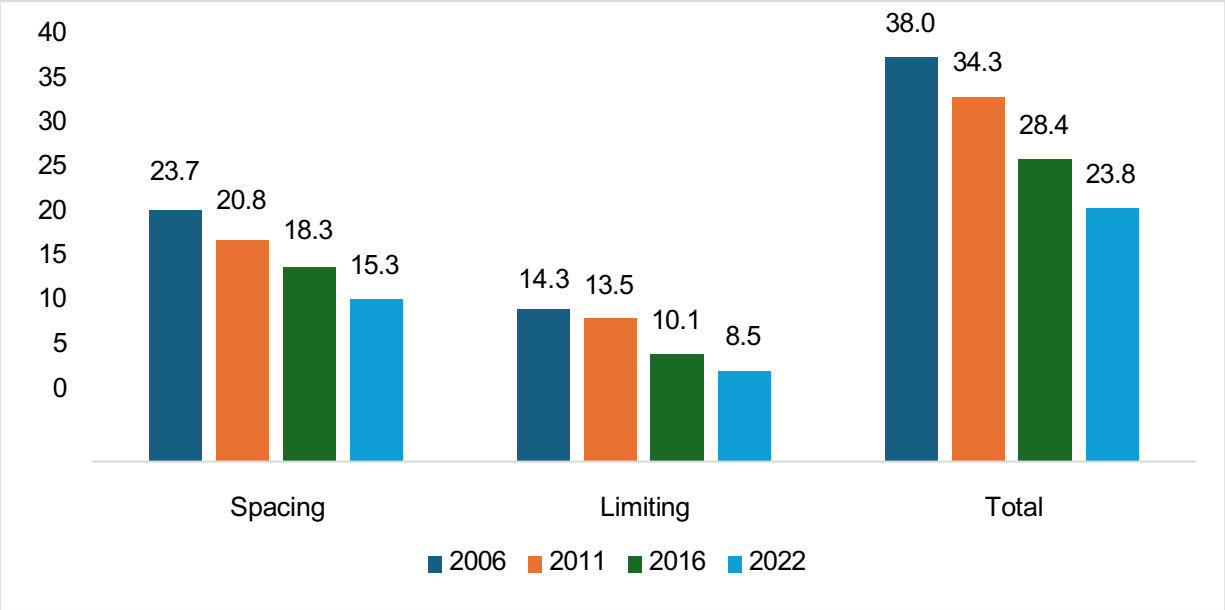
15.7 Current use of contraception

The government of Uganda is committed to increasing modern contraceptive prevalence rate and reducing unmet need for family planning. Current contraceptive use is the cornerstone of family planning, enabling individuals and couples to choose the number and timing of their children, thereby reducing unintended pregnancies and improving reproductive health outcomes. Government has made efforts to expand the range of contraceptive methods available and improve the quality of services.

Most women want family planning for spacing of children. Spacing has health benefits for both the woman and her child. On the other hand, the planners and programme designers want family planning for limiting, that is, to achieve the family size that will transform the population age structure into one that is conducive for development a. With most people in Uganda still desiring large families, family planning will have only the effect of producing large families with well-spaced children, creating a large number of children that are not productive and depend on the working age population as consumers.

Figure 20 shows that the unmet need for Family Planning is at 23.8 percent; this is a reduction from 38.0 percent registered in 2006. This unmet need is higher for Spacing (15.3%) than limiting (8.5%).

Figure 20: Percentage of currently married women aged 15-49 with unmet need for family planning for spacing and limiting



Source: Uganda Demographic and Health Survey

Figure 21: Unmet need for modern methods for married women

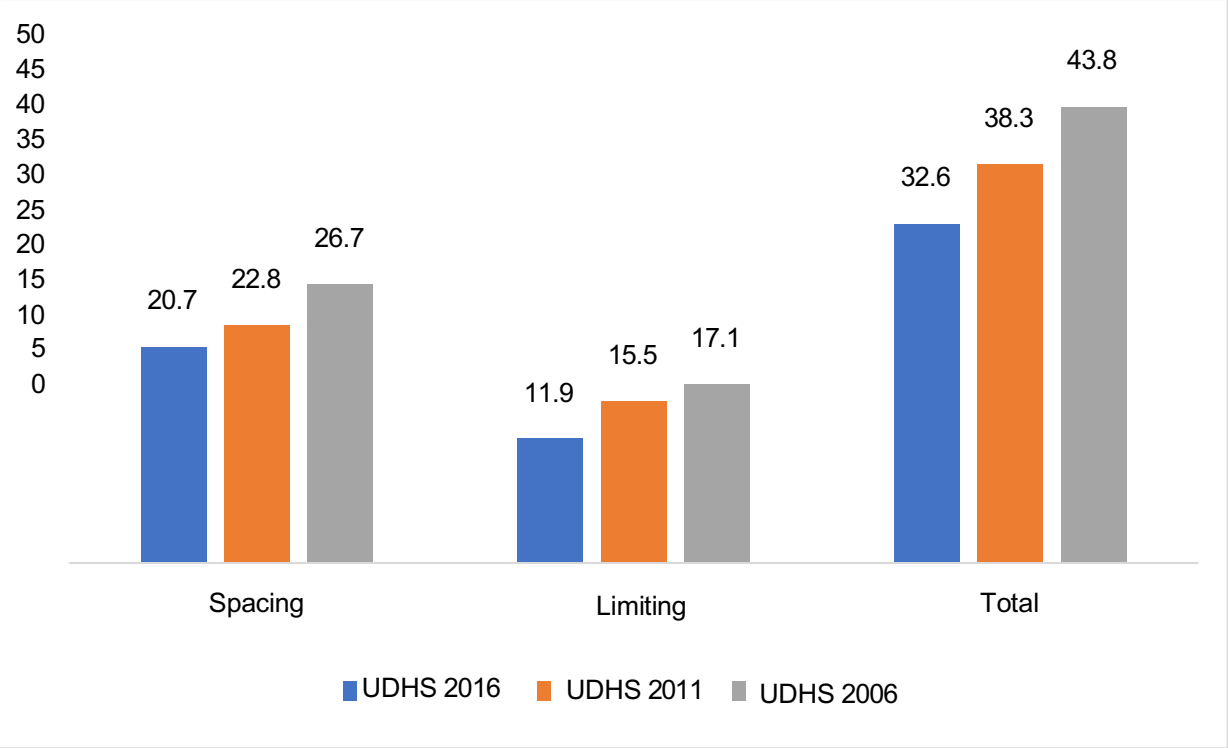


Table 16 below provides details on unmet need for family planning by residence, education level attainment, wealth quintile and age group.

Table 16: Unmet need for family planning among all women, married women and sexually active unmarried women, 2006-2022

Characteristic	2022 UDHS			2016 UDHS			2011 UDHS			2006 UDHS		
	spacing	limiting	Total	spacing	limiting	Total	spacing	limiting	Total	spacing	limiting	Total
Unmet need for family planning for all women												
National	**12.6**	**5.9**	**18.5**	**13.6**	**6.9**	**20.4**	**15.5**	**9.3**	**24.5**	**17**	**9.9**	**26.9**
Residence												
Urban	10.6	4.6	15.1	10.1	4.9	15	11.4	4.2	15.6	10.6	4.8	15.4
Rural	13.6	6.6	20.2	14.8	7.6	22.4	16.1	10.6	26.7	18.3	11	29.3
Education attainment												
No Education	9.4	12.1	213	10.9	15.5	26.4	10.6	17.7	28.3	16.6	16.2	32.8
Primary	13.7	6.5	20.2	15	7.6	22.6	17.3	10.2	27.5	19.3	10.2	29.5
Secondary	11.7	3.4	15.1	11.9	3.3	15.2	13.5	3.6	17.1	11.7	3.5	15.2
Higher	10.8	3.1	13.9	11.4	2.6	14	9.5	3.2	12.7	7.5	3.4	11
Wealth quintile												
Lowest	16.4	6.7	23.1	19.6	9.1	28.7	19.5	13.3	32.9	21.7	12.3	34
Second	14.4	7.4	21.8	15	8.9	24	17.9	12	29.9	21.2	12.3	33.5
Middle	11.8	6.7	18.6	145	7.2	21.7	16.1	9.9	26	18.3	10.7	29
Forth	11.4	5.6	17	11.1	6.1	17.1	14.5	8.8	23.3	16.7	10.4	27.1
Highest	9.9	4	13.9	9.6	4.2	13.8	10.1	4.7	14.8	9.4	5.5	14.9
Age group												
15-19	11.8	0.4	12.3	10.9	0.4	11.3	10.4	0.2	10.5	10.5	0.9	11.4
20-24	18.6	1.1	19.8	21.5	1	22.5	25.2	2.3	27.5	25.2	2.5	27.7
25-29	17.1	2.6	19.7	19.5	3.6	23.1	25.3	6.6	31.9	28.5	7.1	35.6
30-34	14	6.5	20.5	16	10.2	26.2	15.5	17.5	33	21.3	15.7	37
35-39	9.8	13.4	23.2	8.3	17	25.2	10.2	20.3	30.5	12.4	24.5	369
40-44	4.1	18	22.1	2.7	19.5	22.3	3.1	23.4	26.6	3.7	24.6	28.3
45-49	1.9	13.3	15.2	0.9	16	16.9	0.1	15.9	16.1	1.5	14.4	15.9

Table 16: Unmet need for family planning among all women, married women and sexually active unmarried women, 2006-2022

Characteristic	2022 UDHS			2016 UDHS			2011 UDHS			2006 UDHS		
	spacing	limiting	Total	spacing	limiting	Total	spacing	limiting	Total	spacing	limiting	Total
Unmet need for family planning for married women												
National	15.3	8.5	23.8	18.3	10.1	28.4	20.8	13.5	34.3	23.7	14.3	38
Residence												
Urban	12.6	6.8	19.4	14.9	7.9	22.8	15.8	6.9	22.7	18.5	7.5	26
Rural	16.5	9.2	25.7	19.4	10.7	30.1	21.7	14.8	36.5	24.5	15.3	39.8
Education attainment												
No Education	11.7	14.5	26.2	13.1	18	31.1	12.9	21.3	34.1	19.8	1 .5	38.3
Primary	16.7	9.1	25.8	19.7	10.8	30.5	23.8	14.2	38	26.5	14.4	40.9
Secondary	14.6	5.5	2O.1	17.8	5.5	23.4	19.6	6.1	25.7	21.1	7.2	28.3
Higher	11.3	4.8	16.1	16.6	4.1	20.7	13	5.9	18.9	12	6.1	18.1
Wealth quintile												
Lowest	19.8	8.5	28.3	25.4	12	37.3	26	16.3	42.3	27.6	15.1	42.8
Second	17.3	9.8	27.1	20	11.9	31.9	22.8	16.4	39.2	27.3	16.3	43.6
Middle	13.8	10	23.8	18.7	10.5	29.2	20.7	13.5	34.2	25.1	14.4	39.5
Forth	14	8.4	22.4	13.9	9	22.9	20.3	13.9	34.3	23	15.1	38.1
Highest	11.9	6.1	18	14.1	7.3	21.5	14.8	8.1	22.9	14.9	10.3	25.2
Age group												
15-19	28.1	0.7	28.8	29.7	0.7	30.4	30.7	0.6	31.3	32.7	1.7	34.4
20-24	21.5	1.2	22.7	28.3	1	29.3	32.5	2.9	35.4	32.6	2.9	35.5
25-29	19.4	2.8	22.2	23	3.9	26.9	28.2	7.6	3S.7	32.1	7.9	39.9
30-34	15.5	7.3	22.7	18.3	11.5	29.8	17.7	18.9	36.6	25.8	17.3	43.1
35-39	11.3	15.6	26.9	10.1	20.2	30.3	12.1	23.4	35.5	15.1	Z9.1	44.1
40-44	5	20.8	25.9	3.1	23.8	26.9	4	27.9	31.9	5	32	37
45-49	2.5	18.1	20.6	1.1	21.4	22.4	0.2	23.8	24	2.1	18.8	20.9

Table 16: Unmet need for family planning among all women, married women and sexually active unmarried women, 2006-2022

Characteristic	2022 UDHS			2016 UDHS			2011 UDHS			2006 UDHS		
	Spacing	Limiting	Total	Spacing	Limiting	Total	Spacing	Limiting	Total	Spacing	Limiting	Total
Un Met Need Sexually Active Un Married women												
National	30.8	8.2	39.1	229	9	319	19.1	10.6	0.7	19.1	6.9	26.1
Residence												
Urban	29.5	7.2	36.7	18.2	6.7	24.8	18.3	6.3	24.7	13.4	3.8	17.2
Rural	31.8	9	40.8	25.6	10.3	35.9	19.6	13.7	33.4	22	8.5	30.5
Education attainment												
No Education	14.3	29.4	43.7	15.3	33.5	48.8	NA	NA	NA	8.7	23.9	32.6
Primary	31.9	9.4	41.2	26.2	10.5	36.8	16	13.3	0.3	23.3	8.1	314
Secondary	31.8	3.2	35	19.6	4	23.6	28.1	5.9	34	18.9	0.8	19.7
Higher	34.7	2.4	37.2	20	2.5	225	14.3	0.9	15.2	5.6	0	5.6
Wealth quintile												
Lowest	34.4	12.l	46.5	25.1	14	39.l	NA	NA	NA	20.7	U.1	32.9
Second	30.6	11.9	42.5	218	16.9	38.7	NA	NA	NA	26.1	9.3	35.5
Middle	34.5	3.9	38.4	26.6	7.5	34.1	228	22.3	45.2	15.2	117	26.9
Forth	27.3	7.5	34.8	25.6	8.8	34.3	20.3	10.2	30.6	22.2	9.6	318
Highest	29.8	7.4	37.l	18.7	4.4	23.1	16.4	4.4	20.8	17.2	2.2	19.3
Age group												
15-19	53.9	1.1	55	42.8	2.3	45.l	37.5	11	38.6	44.8	0.2	45
20-24	33.1	2.7	35.8	24.5	19	26.4	25	4.1	29	211	2.7	23.8
25-29	25.1	4.5	29.6	17.6	6.1	23.7	14.1	3.6	17.7	16.2	5	212
30-34	20.3	9.8	30.1	16.1	10.2	26.3	7.8	118	19.7	2.9	10.7	13.6
35-39	13.5	15.4	28.9	5.5	20.9	26.4	3.9	19.5	23.4	5.2	14.7	19.9
40-44	5.5	38	43.5	6.2	38.5	44.7	NA	NA	NA	NA	NA	NA
45-49	5.4	27.5	33	3.1	34.8	37.9	NA	NA	NA	NA	NA	NA

15.8 Contraceptive use among women aged 15-49 years.

The contraceptive prevalence rate (CPR) among all women increased from 5.5 percent in 1988 to 32.9 percent in 2022, while modern CPR increased from only 2.7 percent to 29.8 percent. Table 17 shows that although the CPR is highest among urban women in each year, the largest percentage increment has been among women living in rural areas, from 4.1 percent in 1988 to 31.4 percent in 2022. This is also true for modern methods contraceptive prevalence rate (mCPR). Changes in mCPR for women living in rural areas increased from 1.6 percent to 28.7 percent while that of women living in urban areas only increased from 10.7 percent in 1988-89 to 32 percent in 2022. The difference between women living in rural areas and those in urban areas has narrowed over the years covered by the UDHS. This could imply inequities in urban poor women that may be increasing and impacting on access to preferred methods. It could also be a result of the changes in the classification of urban areas, that include areas that are typically rural but classified as part of town councils or even cities.

Women with secondary or higher education have overtime had the highest mCPR compared to their counterparts with primary and no education. However, the last two surveys indicate a narrowed gap between women with only primary education and those with secondary or higher. The mCPR among women with primary education has increased from 2.4 percent in 1988-89 to 30 percent in 2022, while among women with secondary education the increment was from 10.3 percent to 31.9 percent over the same period.

Regarding wealth status, over the years since 1988-89, there has been a clear dose response relationship between wealth and CPR. Contraceptive use has generally been higher among women in the highest wealth quintile in each UDHS.

Education is a known key determinant of contraceptive use. The narrowing gap between women with primary and those with secondary education could be due to the increased access to contraceptive information by programs using different channels, which the women with primary education can access and comprehend easily.

Table 17: Trends in contraceptive use for all women

Characteristic	1988-89 UDHS	1995 UDHS	2000-01 UDHS	2006 UDHS	2011 UDHS	2016 UDHS	2022 UDHS
Any method							
Total	5.5	13.4	20.1	19.6	23.6	30.3	32.9
Residence							
Urban	16.2	26.9	36.1	32.5	33.0	34.2	35.8
Rural	4.1	11.0	16.9	16.9	21.3	28.9	31.4
Education							
No education	2.3	7.3	11.7	11.6	16.6	23.3	22.7
Primary	5.6	13.0	18.0	18.0	21.9	29.0	32.7
Secondary	17.0	28.9	34.2	28.4	28.4	32.7	35.2
Higher	NA	31.3	50.3	43.4	39.9	40.2	39.5
Income Status							
Lowest	NA	8.8	12.7	8.4	12.2	20.4	25.3
Second	NA	8.0	11.8	12.6	18.3	27.6	32.2
Middle	NA	9.6	16.6	15.9	22.7	30.9	34.3
Fourth	NA	12.8	20.2	22.2	26.7	34.6	35.2
Highest	NA	26.4	35.6	33.9	33.4	35.2	36.0
Age							
15-19	2.6	7.2	10.4	6.5	6.8	10.0	10.8
20-24	5.4	13.0	22.3	21.3	22.1	30.9	36.9
25-29	5.7	14.3	24.0	24.3	31.6	41.2	41.3
30-34	6.7	19.6	25.1	27.2	33.5	40.5	44.0
35-39	7.9	17.2	24.5	23.7	34.5	39.8	40.2
40-44	8.6	14.0	23.1	23.7	32.0	38.9	39.8
45-49	7.1	13.3	13.2	18.7	17.5	23.3	27.5
Any modern method							
Total	2.7	7.4	16.5	15.4	20.7	27.3	29.8
Residence							
Urban	10.7	22.0	32.9	28.2	28.5	30.5	32
Rural	1.6	4.8	13.2	12.9	18.7	26.1	28.7
Education							
No education	1.0	2.4	8.6	8.2	14.5	20.6	18.6
Primary	2.4	7.1	14.6	14.3	19.5	26.5	30
Secondary	10.3	20.3	30.1	23.2	24.4	29.5	31.9
Higher	NA	16.6	42.4	34.3	33.1	33.8	34.8
Income Status							
Lowest	NA	2.1	9.4	6.3	10.7	18.9	21.9
Second	NA	2.9	8.2	10.0	16.8	25.5	29.9
Middle	NA	4.2	12.5	11.5	19.5	28.2	31.5
Fourth	NA	5.5	16.8	17.0	24.0	31.0	32.2
Highest	NA	20.9	31.9	28.1	28.5	30.8	32.3
Age							
15-19	1.2	3.4	9.0	5.2	6.0	9.4	9.4
20-24	1.8	6.3	18.7	17.2	19.8	28.3	33.4
25-29	2.6	9.0	20.2	19.7	27.6	37.4	37.7
30-34	3.1	11.5	19.5	22.0	30.0	36.6	41.0
35-39	5.6	10.4	20.8	18.7	30.3	36.0	36.7
40-44	5.4	8.6	17.3	17.2	26.5	33.7	35.1
45-49	2.5	5.7	9.1	13.1	14.1	18.9	24.1

15.9 Contraceptive use among married women

The possibility for sex and the resultant risk of pregnancy are higher among women who are in union or live with partner as if married. Therefore, contraceptive prevalence rate of married women is expected to be higher than among all women combined. The contraceptive prevalence rate (CPR) among married women at the time of each survey has increased from 4.9 percent in 1988 to 42.5 percent in 2022, while modern CPR increased from only 2.5% to 38.3 percent (Table 18).

The difference between all methods CPR and mCPR is the traditional methods CPR. The use of traditional methods of contraception was 4.2 percent in 2022. This has changed from 2.4 percent in 1988-89 survey, reaching a high of 7 percent in 1995 survey, and then dropping. The erratic rise and drops in traditional methods may symbolise women moving from some of the modern methods when they experience side effects, and temporarily settling for traditional methods, which are short term, with minimal side effects, although not as effective. The programs need to aim as minimising the use of less effective traditional methods and move women to more effective modern methods, as we progress towards the FP2030 goals.

Regarding education, there is a clear dose response relationship, with higher proportions of women having higher education more likely to report contraceptive use than those with low or no education. All methods contraceptive prevalence follows the order of education in all survey years; highest among women of tertiary, followed by secondary, primary and lowest among those with no education. This points to the importance of education for the girl child that translates into better reproductive health outcomes, including contraceptive use.

Married women living in the urban areas also had a higher percent of using all methods of contraception, than their rural counterparts in all the survey years. All methods CPR rose from 18 percent among women in urban areas in 1988-89 to 48 percent in 2022 survey, while it rose from a paltry 3.6 percent to 40 among women living in rural areas. It should be noted that women living in rural areas have had a substantial rise overtime to narrow the gap with the urban counterparts. Programs of family planning ought to increase the strategies in rural areas to further narrow the gap and achieve equity. However, with increasing rural urban migration and a big number of the urban poor, interventions in the urban areas should also be intensified to narrow the gap within the urban itself.

Although the gap that is narrowing among women living in the middle and the top two quintile households, women living in the lowest wealth quintile households still lag far behind in use of contraception. These women are most likely to be in urban areas and the poorest regions of the country, that need more attention with targeted programming.

As indicated above, there are also the urban poor that may be masked in better indicators because of the large group in the stratum that are in the top quintile households. Similar trends were observed in use of all methods, are also seen in the use of modern contraceptive methods among married women, regarding education, residence and wealth.

Table 18: Trends in contraceptive use for married women

Characteristic	1988-89 UDHS	1995 UDHS	2000-01 UDHS	2006 UDHS	2011 UDHS	2016 UDHS	2022 UDHS
Any method							
Total	4.9	14.8	22.8	23.7	30	39	42.5
Residence							
Urban	18.0	34.4	46.3	43.1	45.8	46.0	48.0
Rural	3.6	12.2	19.3	20.8	26.9	36.8	40.1
Education							
No education	1.9	8.3	13.2	13.2	17.9	26.0	26.8
Primary	5.8	14.8	21.2	22.4	28.0	37.8	42.4
Secondary	16.5	37.3	47.0	44.2	42.5	45.4	47.2
Higher	NA	NA	57.9	51.0	51.4	51.1	51.0
Income							
Lowest	NA	10.2	15.1	9.9	14.7	24.5	31.4
Second	NA	8.1	13.7	15.7	23.2	34.9	40.0
Middle	NA	10.5	17.2	19.4	29.3	39.7	44.2
Fourth	NA	14.6	23.8	27.6	35.0	45.5	46.1
Highest	NA	32.5	45.8	47.5	46.2	48.8	50.0
Any modern method							
Total	2.5	7.8	18.2	17.9	26.0	34.8	38.3
Residence							
Urban	12.2	28.0	41.6	36.5	39.2	40.6	42.8
Rural	1.5	5.1	14.7	15.1	23.4	33.0	36.3
Education							
No education	0.9	2.6	9.4	9.1	15.5	22.6	21.5
Primary	2.7	7.8	16.8	17.2	24.5	34.2	38.8
Secondary	10.8	25.6	40.1	33.7	36.1	40.4	42.7
Higher	NA	NA	51.1	38.2	44.5	43.0	45.0
Income							
Lowest	NA	2.1	11.3	7.2	12.7	22.4	26.8
Second	NA	2.7	9.3	12.1	21.2	32.2	37.0
Middle	NA	4.1	11.9	13.1	24.7	35.8	40.6
Fourth	NA	6.2	19.5	20.3	31.0	40.2	41.9
Highest	NA	25.8	40.6	37.9	39.1	42.1	44.8

15.10 Contraceptive use among all sexually active unmarried women

Women who are sexually active are those who reported having had sexual intercourse within 30 days before the survey. These women are at higher risk of pregnancy, and ought to be active users of contraceptives if they desire to space or limit childbearing. This indictor considers women who are not in union, for whom it would be assumed that they have a higher likelihood of not desiring to have children and therefore ought to be using contraception.

Trends indicate that there was a rise in use of all methods among unmarried women who are sexually active, from 14.7 percent in 1988-89 to 44 percent in 2022 survey (Table 19). However, there have been inter survey changes, with recent two surveys (2016 and 2022) indicating a reduction in the CPR among these women. This indicator should be noted with concern, because a reduction in this category of women, is likely to result in persistent unintended pregnancies. The reduction in the last 10 years could be due to the limited quality of contraceptive counselling among users where women may not be receiving the method information that is comprehensive enough to minimise discontinuation and create change agents. Such unmarried women could also be fearing side effects (perceived and real) based on information from other users. Programs geared at improving the quality of contraception counselling, measured through the method information index plus, should be enhanced.

Table 19: Trends in contraceptive use for sexually active unmarried women

Characteristic	1988-89 UDHS	1995 UDHS	2000-01 UDHS	2006 UDHS	2011 UDHS	2016 UDHS	2022 UDHS
Any method							
Total	14.7	35.6	48.4	54	51.8	50.6	44.0
Residence							
Urban	25.7	52.7	69.4	66.7	57.8	57.5	48.1
Rural	12.0	28.8	39.4	47.7	47.5	46.8	41.1
Education Status							
No education	7.1	3.9	16.7	24.4	NA	27.7	31.1
Primary	12.3	29.9	39.7	48.3	47.8	45.9	41.4
Secondary	33.4	73.1	74.4	65.1	51.1	62.1	51.0
Higher	NA	NA	NA	87.0	70.0	52.6	44.9
Income Index							
Lowest	NA	10.0	12.0	26.6	NA	39.7	34.4
Second	NA	41.2	34.1	34.4	NA	43.8	43.1
Middle	NA	15.8	45.5	46.2	39.8	50.7	40.3
Fourth	NA	24.8	48.9	58.2	59.9	49.8	47.9
Highest	NA	54.2	66.8	67.5	57.9	58.7	48.4
Any modern method							
Total	7.4	26.5	44	46.9	44.3	47.3	40.1
Residence							
Urban	19.8	47.7	65.3	58.9	48.7	52.4	42.7
Rural	4.4	18.0	34.8	40.8	41.1	44.4	38.2
Education Status							
No education	1.9	3.9	16.7	15.9	NA	25.5	25.6
Primary	5.6	19.9	33.1	43.2	44.1	43.8	37.8
Secondary	21.1	61.3	73.3	57.3	45.3	59.0	47.1
Higher	NA	NA	NA	70.6	45.4	41.3	40.0
Income Index							
Lowest	NA	3.6	3.8	21.2	NA	36.5	33.4
Second	NA	25.5	24.0	32.8	NA	41.7	39.8
Middle	NA	15.8	45.5	40.2	37.4	49.1	36.0
Fourth	NA	11.6	43.3	50.9	54.6	47.6	44.2
Highest	NA	44.8	63.9	57.9	46.2	53.0	42.8

15.11 Contraceptive use among sexually active unmarried adolescent girls and young women.

To understand who is contributing to the CPR among unmarried sexually active women, this section provides a synthesis by age group, to include the adolescent girls, young women and older women. Among sexually active unmarried *Adolescent Girls and Young Women* (AGYW), the CPR has been rising, mainly contributed to by modern methods. However, the CPR is still low, further from the National target among all women. For the adolescent girls 15-19 years who are sexually active, they should ideally be doing something to avoid getting pregnant, given the risk that teenage pregnancies pose. The expectation would thus be universal contraceptive use. However, although there has been a rise in CPR among the adolescent girls from 2.6 percent in 1988-89 survey to 10 percent in the 2016 survey, this is still very low (Table 20). The consequences are indeed observed through the persistently high teenage pregnancy rates in Uganda. Delaying sexual debut should be ideal, but where it has failed, then contraceptive use must be emphasised to avoid the epidemic of pregnancies at such a young age, and the maternal morbidity and mortality that is associated.

For sexually active unmarried young women aged 20-24 years, there has been a rise in CPR from 5.4% in 1988-89 survey to 30.9% in the 2016 survey. Given that these are young women who are sexually active, but not in any union, the CPR should be higher. For women of this age who are un union, CPR is not expected to be as high as those in later years (example after 30 years), because women in this age may be starting their families, and therefore higher fertility desires than for those in the 30s. Like for adolescents, programming needs to focus on the quality of contraceptive service provision, including effective handling of side effects to attract more young women to modern methods of contraception.

By education, CPR and mCPR are highest among AGYW who have secondary or higher education compared to those with primary or no education at all. This outlines the importance of girl child education. Quality Universal secondary education can go further in improving the quality of life in general, including reproductive health. Contraceptive use for all methods and modern methods is also highest among AGYW who live in urban areas, compared to the rural areas. Rural AGYW are likely to be disadvantaged in access to contraceptive information and services. Adolescents in the rural areas who are sexually active are also likely to be from low-income households and less educated than their urban counterparts. Programs targeting this age group in the rural areas may need to be more responsive to their unique needs that may vary for urban adolescent girls. Rural adolescent girls are likely to fear to access contraception from facilities where adults too access and are also likely to experience stigma when they do access.

Table 20: Trends in contraceptive use among sexually active unmarried adolescent girls and young women, 1988 to 2016

Characteristic	1988-89 UDHS		1995 UDHS		2000-01 UDHS		2006 UDHS		2011 UDHS		2016 UDHS	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Any method												
Total	2.6	5.4	7.2	13	10.4	22.3	6.5	21.3	6.8	22.1	10.0	30.9
Urban	5.8	14.6	13.4	24.5	19.5	43.2	11	37.4	8.8	32.7	11.1	34.1
Rural	2.1	4	5.9	10.8	8.2	17.1	5.5	16.8	6.3	18.5	9.7	29.6
No education	1.2	1.2	4.7	5.5	1.5	10.3	1.8	10.2	5.7	12.2	4.1	16.6
Primary	1.8	4.8	6.3	11.7	9.4	18.8	4.5	17.6	5.9	19.6	8.9	29.3
Secondary	9.5	16.7	13.5	28.7	16.3	39.7	11.1	32.5	7.6	25.9	12.2	34.8
Higher	NA	NA	NA	NA	NA	41	19.9	36.4	31.9	30.4	19.2	30.4
Any modern method												
Total	1.2	1.8	3.4	6.3	9	18.7	5.2	17.2	6	19.8	9.4	28.3
Urban	4	8.2	9.8	20.6	18.5	39.3	9.9	32.9	8.8	28.3	10.2	31.4
Rural	0.8	0.9	2.1	3.5	6.7	13.6	4.2	12.7	5.4	16.9	9.2	27
Education												
No education	0.7	0	2	1.4	0.4	8.2	0	4.8	3.8	11.8	4.1	15.1
Primary	0.6	1.5	2.5	5.4	7.8	15.7	3.3	14.2	5.6	17.8	8.4	27.1
Secondary	5.8	7.3	8.8	16.6	15.6	34.2	9.8	26.8	7.3	22.5	11.2	32.4
Higher	NA	NA	NA	NA	NA	32.9	13	33.1	6	27.7	19.2	24.3

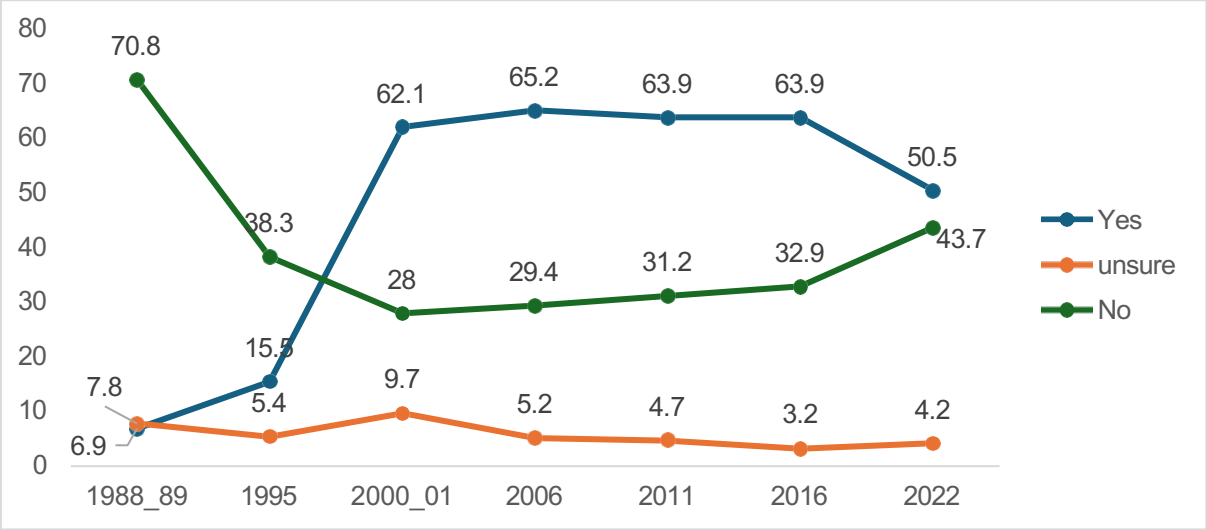
15.12 Intention for the future use of contraception

The future use of contraception is dependent on increased access to a wider range of methods, including innovations like longer-acting contraceptives and non-hormonal options, alongside a focus on improving access, quality of care, and addressing social barriers to contraceptive use. Intention for future use of contraceptive is a better predictor of further use compared to unmet need for contraceptive (Figure 22). However, this indicator is largely collected among non-current users of contraceptive at the time of the surveys. We present trends of the intention for future use over the last 7 DHSs in Uganda, and describe this indicator stratified by women's characteristics.

Fifty-one percent of currently married women who are nonusers of contraception intend to use family planning in the future, while (44%) do not. The proportion of currently married women who do not intend to use any method of contraception has increased from 29.4 percent in 2006 to 43.7 percent in 2022.

Although the indicator steadily increased from 6.9% in 1988/89 to 65.2% in 2006, we observed a slight decline to 63.9% both in 2011 and 2016 and further dropping to 50.3% in the recent 2022 survey. Women not sure of future use declined from 7.8% in 1988/89 to 4.3% in 2022 survey. The decline in the intention of women to use contraceptives is attributed to several factors including, age, religion, education, desired family size, and previous use of contraceptives.

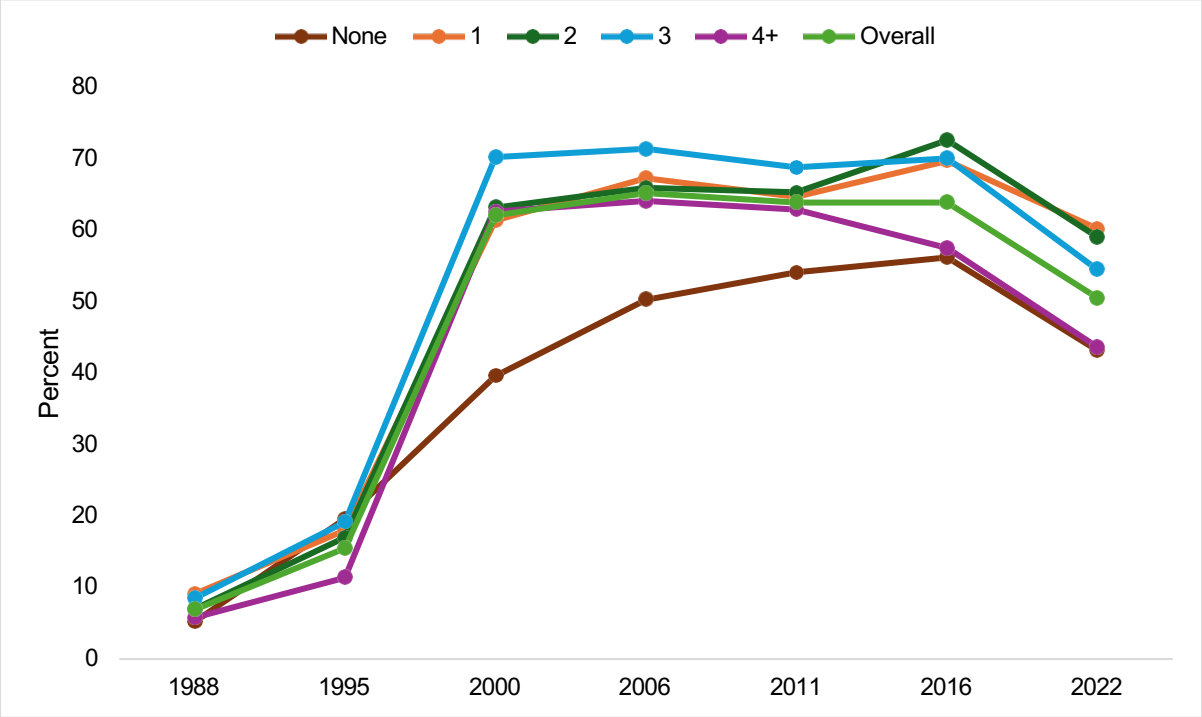
Figure 22: Overall intention for future use of contraceptives among non-current Family Planning (FP) users



Source: Uganda Demographic and Health Survey

Parity refers to the number of times a woman has given birth to a viable fetus. Intention for future contraceptive use was lowest in the first two surveys 1988/89 and 1995 among women of parity 4+, but subsequently prime gravida women (parity 0) became the lowest. However as of 2016 and 2022 surveys, the percent of both the primigravida and 4+ parity women with intention for future use the lowest and the same, followed by parity 3 and parity1 and 2 as of 2022 survey. It is surprising that women of higher parity (4+) have similar intentions towards future use as the primigravida, who are not limiters. (*Figure 23 and Table 21)*.

Figure 23: Intention for the future use of contraception by parity among non-FP users



Source: Uganda Demographic and Health Survey

Table 21: Intention to use Contraceptives by woman's Parity

Survey year / Parity	None	1	2	3	4+	Total
Intends to use						
2022 UDHS	43.2	60.2	59.0	54.5	43.6	50.5
2016 UDHS	56.2	69.7	72.6	70.1	57.5	63.9
2011 UDHS	54.1	64.7	65.3	68.8	62.9	63.9
2006 UDHS	50.3	67.3	65.9	71.4	64.1	65.2
2000-01 UDHS	39.6	61.4	63.2	70.2	62.6	62.1
1995 UDHS	19.6	18.0	17.0	19.2	11.4	15.5
1988-89 UDHS	5.2	9.1	7.0	8.5	5.8	6.9
Unsure						
2022 UDHS	4.7	5.8	3.9	3.9	3.8	4.2
2016 UDHS	6.2	4.0	2.7	3.8	2.6	3.2
2011 UDHS	7.9	3.7	4.6	4.4	4.8	4.7
2006 UDHS	6.4	7.8	6.9	3.7	4.3	5.2
2000-01 UDHS	15.0	13.5	9.4	8.5	8.2	9.7
1995 UDHS	8.2	4.9	5.1	5.7	4.9	5.4
1988-89 UDHS	7.9	11.0	6.8	9.6	6.4	7.8
Does not intend to use						
2022 UDHS	51.3	33.2	35.2	39.5	50.8	43.7
2016 UDHS	37.6	26.3	24.7	26.2	39.9	32.9
2011 UDHS	37.3	31.5	29.7	26.4	32.3	31.2
2006 UDHS	42.7	24.7	27.2	24.6	31.4	29.4
2000-01 UDHS	45.2	25.0	27.2	21.3	29.1	28.0
1995 UDHS	54.5	38.9	34.8	37.1	36.3	38.3
1988-89 UDHS	83.9	73.9	72.8	68.8	66.8	70.8

16 Conclusion and Recommendation

16.6 Conclusion

Uganda has a large young population with a high unmet need for family planning (FP). The age at first sexual debut is lower compared to age at first contraceptive use, fuelling teenage pregnancy and related high fertility. Despite the government efforts to reduce fertility levels and increase uptake of family planning services, family planning use was still low at 30% which is the lowest in the East African region. Although there have been many efforts to improve access to and uptake of contraception, the improvements have been slow and have not matched the targets and commitments the country set. This poses a great threat to socio-economic development and well-being of the population. The high birth rates not only affect maternal and child mortality but frustrate governments' efforts in the provision of social and health services to communities.

Family planning utilization is negatively affected by inadequate awareness and knowledge of different FP options among WRA and adolescents, socio-cultural and community perceptions and biases regarding specific contraceptive methods, inadequate trust in the health system compounded by provider bias, and the cost and limited availability of services.

There are widespread disparities in fertility and family planning use. Although urban areas are often considered and reported to be better off due to the wider availability of and apparent proximity to services, the increasing intra-urban inequalities are affecting access to and use of FP services. Developmental focus has typically been on rural areas, resulting in limited free, quality primary health care in urban areas which further affects access to and use of FP services.

16.7 Recommendations

Addressing/ generating FP demand

1. Develop targeted communication and outreach strategies to reach young people and other vulnerable groups, addressing misconceptions and promoting informed choice.
2. Scale up youth-friendly services and ensure that facilities are equipped to meet the specific needs of adolescents.
3. FP Programmes should provide information on the benefits of contraception while highlighting the health, economic, and social benefits of FP for individuals, families, and communities.
4. Address stigma surrounding FP, particularly among adolescents and unmarried women through community sensitization and targeted interventions.

5. Involve communities in planning and implementation and empower community health workers to promote family planning.
6. Discussions about family planning at health facilities or during VHT home visits should address non-users' concerns, misconceptions, and barriers to FP adoption because they aim to promote informed decision-making and encourage uptake of FP methods by providing accurate information and addressing individual needs. Discussions should also provide evidence-based information and address individual fears and misconceptions.
7. Promote male involvement and encourage open communication so that both partners are involved in the decision-making process. This will lead to greater support and shared responsibility.
8. Understand that women's intentions to use family planning is crucial for family planning programs and policies to effectively target resources and interventions to increase contraceptive uptake and reduce maternal and child mortality.
9. Promote women's education, awareness through the media (local radios), and economic empowerment to enable them access FP methods.

Service delivery

10. Invest in provider training and support to improve communication skills, reduce provider bias and thus enhance the quality of FP services.
11. Adopt strategies to optimize Health workers' and VHT's time and resources for individual counselling sessions and ensure that non-users receive adequate information and support.
12. Prioritize community-based distribution, task-shifting to lower-level health workers, and expand access to self-administered options like DMPA-SC self-injection, especially for adolescents and hard-to-reach populations.

Policy

13. Regional disparity in family planning use calls for increasing investments in rural areas to further narrow the gap and achieve equity. However, with increasing rural urban migration and a big number of the urban poor, interventions in the urban areas should also be maintained or intensified to narrow the gap within the urban itself. In addition, ensure that programs targeting adolescents and young people in the rural areas are more responsive to their unique needs that may be different for urban adolescent girls.
14. Policymakers need to amend the existing policies to promote the use of FP methods among young women since they are fewer users of FP methods as compared to older women.

Research

15. With increasing interest in using the Method Information Index (MII) to monitor FP programming and performance, recognizing how this measure may differ from its use in national surveys is necessary. Integrate MII into existing data collection tools, to make it a practical measure for tracking progress and identifying areas for intervention.
16. Strengthen data generation, analysis, and use data to inform decision-making and resource allocation/expenditure.

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